EVALUATION REPORT

OF THE

SINGLE ENTRY POINT PILOT PROJECT

BUREAU DE CONSULTATION ÉVAco enr.

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Rita-Éva Lapointe
Evaluator

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INTRODUCTION

Following an extensive study (1987) of long-term care services in New Brunswick, the Department of Health and Community Services' Long-Term Care Strategy Committee determined there was a need to establish a single point of access to long-term care and to develop a pilot project in order to test and evaluate the model. After consultation with key stakeholders, it was decided to test a service delivery model in two regions of the province.

In April 1989, the Minister announced that the Single Entry Point model would be tested during the 1989-1990 fiscal year. November 1 was the date subsequently chosen for implementation of the project, which was to last for one year and would be evaluated as the results became available.

BACKGROUND

The model tested in New Brunswick was based primarily on experimental research and studies conducted in the United States, a study of a single entry model by the federal Department of National Health and Welfare, the results of similar models implemented in Alberta and Manitoba, and finally, the knowledge and expertise of persons who, at the provincial level, worked on the Design Committee and the Advisory Committee.

PHILOSOPHY OF THE SINGLE ENTRY MODEL - The goal of the model tested is to reduce the premature institutionalization of seniors who, with additional help and services, could continue to live at home. Owing to the effects of the natural aging process on the functional capacities of elderly persons, many need assistance whether it be a little or a lot, intermittent or constantly, or immediately in crisis situations. These elderly need help not only with regard to health problems, but also in carrying out the normal activities of daily living. According to the philosophy underlying the Single Entry Point model, seniors, regardless of the number and nature of their needs, must have one place to go to where their request for assistance will be dealt with directly and from which they will have access to a continuum of services provided within a framework implementing the problem-solving approach.

The Single Entry Point model presupposes the existence or the establishment of a continuum of services capable of meeting different kinds of needs with varying degrees of seriousness. It also presupposes a mechanism for coordinating services delivered by units that answer to different types of administrations such as non-profit, private, semi-private, or public agencies, and in some instances, to different sectors of the same agency. The model further presupposes adopting an approach whereby solving the problem presented by the person requesting assistance is the focus of the actions undertaken. Lastly, the model presupposes that persons in charge of the agencies concerned agree on a standard procedure for access to the services they offer.

DESIGN OF THE MODEL - A provincial Design Committee, representing a range of stakeholders, project partners and project coordinators developed the disign of a single access model for New Brunswick which included a series of objectives to be met, a set of guidelines and procedures to be followed as well as decision-making structures. It provided for the use of specific instruments, the most important of which is a multidisciplinary assessment tool. An integrated record for the individual is another. In addition, unlike others of its kind, the model developed in New Brunswick is under the primary responsibility of the community services component of the Department of Health and Community Services.

During the design process, a presentation of the proposed model was made to an Advisory Committee, composed of persons representing the Department and major stakeholders involved in long-term care, who prepared recommendations for the Deputy Minister of the Department of Health and Community Services. This was the model that underwent testing in the 1989-1990 Single Entry Point pilot project.

In addition to the Family and Community Social Services, to meet its objectives, the pilot project required the participation of the Extra-Mural Hospital as well as the contribution of several departmental sectors such as Institutional Services and Public Health Services.

SELECTION OF THE TWO PILOT REGIONS - The Fredericton region and the Péninsule acadienne region were selected to pilot the model. One of the reasons for this choice, if not the main reason, was that both regions were equipped with a service infrastructure that was sufficiently strong and extensive to meet the needs that would be identified right from the beginning of the pilot project. In addition, these regions being situated in different parts of the province, offered urban and rural zones and were capable of representing the province's anglophone and francophone communities. It should also be mentioned that each region agreed to make part of their existing resources available to the pilot project.

APPROACH USED DURING EVALUATION

The evaluation conducted took the form of a study designed to describe the main characteristics of the pilot project and the essential aspects of its implementation, survey opinions regarding the strengths and weaknesses of the model tested, and compile relevant data for the purpose of subsequent decision-making.

MANDATE OF THE EVALUATION - According to the plan presented in March 1990, the evaluation would provide the most complete answers possible to the following five questions:

a) What are the main characteristics of the Single Entry Point model applied?
b) What were the profiles of needs to be met in order to enable the frail elderly to live at home longer?
c) What were the costs in terms of time and money?
d) What were the short-term impacts of the Single Entry Point model applied?
e) What are the strengths and weaknesses of the model?

A sixth question was tentatively included in the evaluation plan: What would be the global profile of needs to be met in order to enable frail seniors in other regions of the province to live at home longer? However owing to time limitations, it was not possible to consider this question.

Besides fulfilling its original mandate, we believe that a second reading the data gathered during the evaluation would make it possible to draw conclusions relating to the client-focused and organizational goals of the Single Entry Point model.

SOURCES OF INFORMATION - The information required in order to respond to the five evaluation questions were obtained from various sources, in accordance with the schedule below:

- documentation made available to persons involved in the pilot project.;
- client records:
  - records of frail seniors receiving enriched services - March and September 1990;
  - records of seniors receiving regular services - June, July and August 1990;
  - records of persons whose names were on the nursing home waiting list - November 1990;
- series of interviews with clients receiving enriched services - November 1990;
- series of interviews with informal caregivers - November 1990;
- questionnaire for Single Entry Point professionals - November 1990;
- time study - November and December 1990;
- questionnaire for provincial stakeholders - December 1990;
- questionnaire for nursing homes, service providers, and hospitals in the pilot regions - December 1990;
- series of interviews with persons involved in the pilot project as regional administrators - December 1990 and January 1991;
- statistics on the nursing home waiting list - January 1991;
- cost-related data - January 1991.

At the beginning of each report on the results in the following chapters, detailed information is given on the procedures used to gather data from these sources.

METHODOLOGICAL APPROACH - In order to produce data reflecting the reality of the situations observed and to respond to the five questions contained in the evaluation mandate, three methodological approaches were used to evaluate the pilot project: analysis of documentation, formation of cohorts and representative groups; and, surveys by means of interviews and questionnaires. An analysis of the available documentation (see Appendix A) served as the basis for preparing the first chapter of the report, whose goal was to describe the different components of the Single Entry Point model. To study the needs to be met for the various clientele two cohorts were formed (the membership of each group was determined by the time period chosen) and six other groups whose numbers were set at 30 or more, depending on the desired representation. Analysis of the data is presented in various sections of the report. Finally, interviews and questionnaires, leaving considerable space for the respondents' personal comments, were used to determine the level of satisfaction with the model and determine its impact as well as its strengths and weaknesses. The satisfaction survey involved 50% of the frail elders forming the cohorts along with their informal caregivers chosen on a simple random basis. The other interviews and questionnaires were sent out to all the persons involved in the project with an overall response rate of 80%.

Since the pilot project took place over a period of twelve months, the data gathered reflects only the short-term impact of the Single Entry Point model. However, exhaustive documentation was distributed to those responsible for the Single Entry Point so that new cohorts can be formed over the years in view of establishing a bank of information. On the basis of this information, and any supplementary data deemed useful, it will be possible to conduct a longitudinal study and thereby trace developments in this sector.

INTERPRETATION OF RESULTS - Certain factors related to the model studied or certain limitations inherent in this type of evaluation, interpretation of the results must be cautious.

The Single Entry Point process comprises various components: multidisciplinary assessment, service plan, panel and case management. Therefore, the effects and impact identified in this study cannot be attributed to one component or the other, but rather to the model as a whole. Furthermore, the evaluation was conducted parallel to the first application of the model. Therefore to some extent, the opinions expressed reflect problems associated with implementing any new process or procedure. The profile of needs is an exception, since the second series of data was collected at the end of the testing period.

As for the techniques used in evaluating the project, time constraints prevented us from formally testing the survey questionnaires used. We therefore used two procedures designed to minimize the effects of this omission: we included "no opinion" as a possible response and inserted a few lines below most of the questions to encourage respondents to make comments. Some of the comments received give us reason to believe that these procedures were effective in tracing of ambiguous or less relevant questions . It should also be noted that, in a few cases, when entering data relating to the general profile and the profile of needs, we used the same code for cases where "not relevant" was given as a response and cases where no answer was given. As a result, we are unable to distinguish between these two categories when interpreting the results. Lastly, some attempts to collect data proved unsuccessful for various reasons. This was particularly true for information pertaining to crisis situations (number of interventions requested, comparison with earlier situation, reaction time, etc.). The same applies to the data pertaining to the average waiting period before being admitted to a nursing home during the year preceding the project in the pilot regions.

Those are the main factors which need to be taken into account during the interpretation of the results presented in the following pages.

CHAPTER I

THE MODEL

A. PRINCIPLES AND GOALS

At the beginning of the design phase for the pilot project, a set of principles were stated[1]. These principles guided the work of both the Design and the Advisory committees.

PRINCIPLES

1. Services should enhance and not replace the natural support system.
2. Service design should promote and foster independence and the importance of accepting personal responsibility for health.
3. The dignity and rights of individuals and families should be respected.
4. People whose lives are affected by a decision should be part of the process of arriving at that decision.
5. Families should not be burdened beyond reason.
6. Services must be delivered in the language of choice.
7. Services are appropriate for identified needs.
8. The primary determinant of need should be the functional limitations of individuals and their natural support systems.
9. Utilization of services should be at a minimal level and the least expensive alternative required to maintain or improve the client's level of functioning in the community setting.
10. Nursing Homes should be considered only after all community options have been considered.
11. Service design should include a prevention component.
12. Design should promote continuity of care and formalize the linkages between services.
13. A standardized methodology for each pilot region is used to identify needs, and to plan and initiate service.

During the design process a set of two client-focused service goals and four organizational service goals were identified[2]

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[1] Single Point of Entry - Document 1 - Corporate Plan. Draft: July 2, 1989. p. 11.

[2] Design for Pilot Project on Single Entry Point. March 1990.

CLIENTS FOCUSED GOALS

1. To maintain the autonomy of seniors in their home (who are requesting service), while respecting the right of individuals to make their own decisions.
2. To maintain or increase the senior's capacity for self-care and the capacity of primary caregivers to care for the frail elderly so that the senior can continue living in the community.

ORGANIZATIONAL GOALS

1. To increase and improve coordination of service delivery in the community; to improve coordination and communication among professionals serving the seniors population; to deliver the necessary community services most efficiently.
2. To accurately assess the needs that must be met to permit seniors to live in the community; to identify the type and quantity of additional services that need to be developed including identifying if there are regional differences.
3. To provide accountability for decision-making and spending under the project.
4. To reduce nursing home waiting lists.

B. PROCESS

Three main activities form the process for the single entry delivery model, namely: initial intake, multi-disciplinary assessment (including service planning and panelling, if needed) and case management.. Each of these activities is described in terms of the procedures followed, professionals involved, instruments used and time frame. The main source of information are documents describing the activities, with an emphasis on the most recent. The documentation currently available appears in Appendix A while Appendix B presents some key documents that are frequently referred to in this report.

B.1 INTAKE - A single point of access to services is to be provided in the pilot regions by the Family and Community Social Services offices and the Extra-Mural Hospital. This implies integrated access procedures.

> "When a client is referred or addresses himself to one of these offices, the same intake information is collected. Based on the identified problem at Intake, the request to

initiate the assessment process is forwarded by the office receiving the referral/request to the Extra-Mural nurse or the FCSS social worker. From the client's point of view, there is thus a single point of access/entry as he is not directed to the alternate office even if services would be more appropriately requested of that office[3].

SUMMARY OF PROCEDURES - Whenever a referral or a request is received from a person aged 65 or over, residing in a Single Entry Point pilot region, intake information is collected. Then, one or more of the following steps can be taken: 1) crisis intervention and urgent assessment initiated; 2) guidance given; 3) re-routing to another community service(s) ; 4) assignment for SEP assessment. The basic eligibility criteria for the Single Entry Point pilot project applied at intake are age and residency. "Residency" was defined as follows: "must live within designated demonstration areas, in a home, nursing home, hospital or special care home [4], etc.

PERSONS INVOLVED - Following initial contact with a prospective client, the case is assigned to one member of the team, a social worker or a nurse, who proceeds to collect intake information.

INSTRUMENTS OR FORMS USED - As a result of the intake procedures, information on elements listed in section 1-A through 1-I of the New Brunswick Assessment and Continuing Care Instrument (NBACCI) form is completed.

TIME FRAME - Intake should be completed no later than 2 working days following the day of referral or initial contact. In case of crisis, the client is referred for assessment as soon as the crisis situation is stabilized.[5]

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[3] Address to N.B. Association of Nursing Homes. Gérard M. Doucet. May 24, 1990.

[4] SEP Provincial Design Committee Meeting. September 15, 1989. Recording of Proceedings. p. 3.

[5] Recommendations - Subcommittee on Case Management. Provincial Design Committee. August 1989.

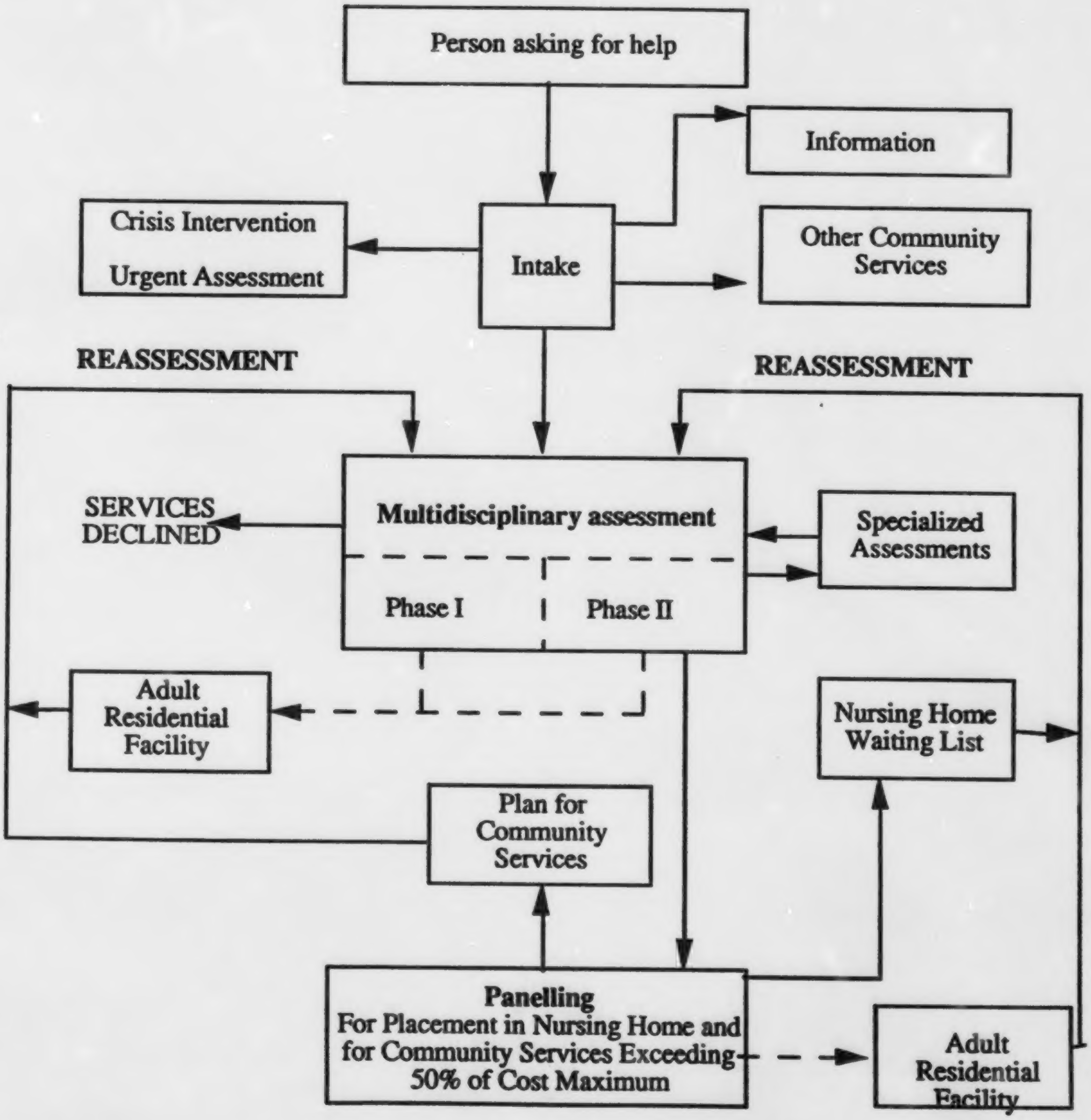
B.2 ASSESSMENT - Assessment is the second step in the process, if indicated by intake. An assessment may be initiated by either member of the multidisciplinary team. As depicted on page 11, assessment is central to the model. It ends with service planning and panelling, if appropriate.

SUMMARY OF PROCEDURES - During assessment, the following activities are completed:

1 - collection of data;
2 - definition of presenting problem(s);
3 - identification of remediable clinical, social and psychological problem(s);
4 - identification of personal, family or community support;
5 - identification of service need(s);
6 - preparation of the service plan;
7 - presentation to panel, if appropriate.

The assessment, which is designed to be multidisciplinary, includes a health and a social component. One member of the multidisciplinary team initiates the assessment, a social worker or a nurse as the case may be after which the other team member may be requested to complete the other part of the assessment, if appropriate, and to participate in service planning thereafter. Each member of the team can identify clinical, social and psychological problems; each can determine whether or not they are remediable; and finally, each can identify the services needed. Based on indicators in the assessment instrument, specialized assessors such as a physician, physiotherapist, occupational therapist, psychologist, psychiatrist, etc. may be called upon during the assessment process.

FIGURE
SINGLE ENTRY POINT PROCESS
DEPARTMENT OF HEALTH AND COMMUNITY SERVICES


Person asking for help
Information
Crisis Intervention
Urgent Assessment
Intake
Other Community Services
REASSESSMENT
REASSESSMENT
SERVICES DECLINED
Multidisciplinary assessment
Phase I
Phase II
Specialized Assessments
Adult Residential Facility
Nursing Home Waiting List
Plan for Community Services
Panelling
For Placement in Nursing Home and for Community Services Exceeding 50% of Cost Maximum
Adult Residential Facility

SERVICE PLANNING - Once the assessment has been completed, a comprehensive service plan and a global budget is developed by either assessor or by both as a team. In order to include SEP enriched services in the service plan, all of the following four eligibility criteria must be met[6]:

I Demographic

a) Must be 65 years of age;
b) Must live within designated demonstration areas, in home, nursing home, hospital, special care home, etc.

II Functional

a) Moderate risk in the Activities of Daily Living (ADL) [7] **or two** moderate limitations in same;

- or -

High risk in the Instrumental Activities of Daily Living (IADL) [8] **or three** high limitations in same;

- or -

Moderate risk in cognitive functioning;

AND

b) Two unmet needs in ADL, or IADL;

- or -

Fragile informal support system.

III Commitment

a) Senior must be willing to participate in the project;
b) Primary caregiver, where available, must be willing to participate in the project.

IV Cost

The maximum cost for social support services does not exceed $1470 per month.

The service plan is to be developed including the client, as much as possible, significant member(s) of his or her informal support network[9] and in close collaboration with persons involved in supporting and or providing services to the client. The level of authority delegated to the SEP regional coordinator for approving support services will be a regional decision.

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[6] SEP Provincial Design Committee Meeting. September 15, 1989. Recording of Proceedings. p. 3.

[7]. Activities of daily living (ADL) are defined as bathing, toileting, dressing, eating and walking.

[8]. Instrumental activities of daily living (IADL) are defined as telephoning, shopping, banking and money handling, doing housework, taking own medicine and preparing own meals.

[9] Recommendations of the Subcommittee on Case Management, August 1989.

PANEL - The assessment process can include presentation of the case to a multidisciplinary panel. The panel[10] must review all cases requesting to be placed on the nursing home waiting list or when nursing home placement is recommended by the team of assessors. As well, the panel reviews all cases having a service plan exceeding 50% of the cost maximum for support services

The multidisciplinary panel is comprised of a chairperson, the SEP regional coordinator, and three appointed members: a senior community social worker, a senior community nurse and a physician with training in geriatrics, when possible. Alternates for each member should also be appointed. Panel decisions are to be unanimous or 2 out of 3 and official minutes taken. The presence of one or both assessors is necessary. The client and the caregiver may also be present for the presentation, if deemed appropriate. The level of authority delegated to the Single Entry Point regional coordinator for approving support services will be a regional decision.

Following decisions taken by the panel, the case manager will implement and monitor the presented or revised service plan.

INSTRUMENTS OR FORMS USED - Most of the information gathered during assessment is entered on the New Brunswick Assessment for Continuing Care Instrument. If appropriate additional assessment tools may be used such as Caregiver Strain, Mini Mental State, Sleep Disturbance, Home Safety, Alcohol and Drug Intake.

TIME FRAME - The first part of the assessment (social or health) should be completed no later than 10 working days following receipt of the referral. The other part of the assessment should be completed no later than 10 working days following completion of the first part.

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[10] Recording of Proceedings (Design Committee) September, 1989. .Appendix A - Advisory Committee and Departmental Decisions Concerning Basic Design Components. September 1989.

In some cases, both parts of the assessment may not have to be completed:

> Case coordinator has discretionary spending up to 1/4 of the cost maximum. This also allows the worker to complete only his or her part of the assessment without calling in his or her partner to complete the multidisciplinary assessment. Specific psychosocial and clinical indicators of risk will be provided in the assessment kit so that the case coordinator at his or her own discretion will call in for a completed assessment by his or her partner before the 1/4 discretionary level [11].

The maximum time lapse between receipt of a referral to completion of the service plan and budget is not to exceed 30 working days [12]. It should take no more than one week for the panel to review a case.

The intent is to accomplish the total assessment process in a shorter time frame than that allotted (30 days plus one week) whenever possible. During the course of the project, this time frame should be tested, monitored and readjusted as it is judged to be too long [13].

B.3 CASE MANAGEMENT [14] - The third step in the process is case management. The basic goal of case management is to provide the most appropriate service as efficiently and as cost-effectively as possible. For the individual, the case manager is the contact person who provides access to and coordinates delivery of needed services. She or he monitors implementation of all aspects of the service plan and the client's satisfaction with service delivery. Monitoring is conducted on an ongoing basis through formal and informal meetings with all those involved in providing support and service.

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[11] First Report - Subcommittee on Intake, Assessment and Crisis Intervention. Addendum: August 23, 1989.

[12] Recommendations - Subcommittee on Case Management. August 1989.

[13] Recording of Proceedings (Design Committee Meeting) - September, 1989. Appendix A - Advisory Committee and Departmental Decisions Concerning Basic Design Components. September 1989.

[14] Recommendations - Subcommittee on Case Management. August 1989.

SUMMARY OF PROCEDURES - Besides initiating or participating in assessment and service planning, the case manager performs many tasks which could be summarized as follows[15]:

1 - Implementation of service plan;
2 - Monitoring of service plan;
3 - Reassessment of client need and modification of the service plan, if necessary.

Usually, the case manager has been involved in assessing the case, preparing the service plan and, when appropriate, presenting it to the panel. This professional will thus have essential information to implement and monitor the service plan.

Part of the assessment and case planning processes require that personalized consultation by the case manager be given to the informal caregiver in order to clarify caregiver service and educational needs. During the monitoring of the service plan, the case manager provides ongoing counselling in the area of caregiver support and ensures that contact has been made between the caregiver and the appropriate agencies.

One of the objectives of the Single Entry Point pilot project is to increase and improve coordination of service delivery in the community and to improve coordination and communication among professionals serving the senior population. The Provincial Design Task Group on Linkages recommended[16] ways to insure that the need for formal linkages is met at regional, departmental and governmental levels.

C. SERVICE OPTIONS

According to the Task Group on Support to Caregivers[17], "research demonstrates that caregiving by the informal networks (from kin and friends) is the primary source of assistance for seniors in contemporary society." The Group developed a comprehensive list of options for providing clients with health care services, social services, and community services[18].

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[15] Recommendations - Subcommittee on Case Management. August 1989.

[16] Linkages in a Single Point of Entry. Provincial Design Task Group on Linkages. September 13, 1989.

[17] Determining Service Options. Design Committee Task Group on Service Options. August 1989.

Through the Single Entry Point model, service options were made available to a targeted group of the frail elderly who were at high risk of being placed in a nursing home, as well as to those persons in their surroundings who had assumed the role of a caregiver.

Each of the following service option is described in detail in the document prepared by the task group (see Appendix B):

1. Geriatric Assessment
2. Homemaker Services
3. Meals-on-Wheels
4. Home Care Nursing Services
5. Equipment and Supplies
6. Emergency Service
7. Relief or Respite Service
8. Counselling Services
9. Mental Health Services
10. Residential Services
11. Home Health Services
12. Community Education
13. Repair and Maintenance Service
14. Transportation Services

The term enriched services is used because the Single Entry Point makes it possible to offer more services (limit of $1470). It also develops services that did not exist in the region before and facilitates access to services that were formerly inaccessible.

D. OTHER MODALITIES FOR THE APPLICATION OF THE MODEL

Testing the model revealed other modalities of applying the Single Entry Point process. The following were identified during evaluation of the pilot project.

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[18] Support to Caregivers. Design Committee Task Group on Support to Caregivers. August 1989.

At one intake point, procedures associated with intake have been entrusted to persons other than professionals on the multidisciplinary team.

The panel has been considered just as much an authority on decision-making as on making recommendations.(in the first case, he Executive Director had delegated certain of his responsibilities); for some cases, the panel was also considered as a medium for consultation.

As for the application of eligibility criteria, implementation revealed that one may:

-verify the eligibility of all cases turning to the Single Entry Point (universal application)

-verify the eligibility of cases whose service plan cost is more than $400 for the Department (first modality of selective application)

-verify the eligibility of cases that, in the opinion of the professionals involved in assessing them, are eligible for enriched services (second modality of selective application)

During the pilot project, persons who, without an informal support network, have managed to maintain a degree of autonomy have been given with benefit the Single Entry Point's enriched services.

These modalities of application were not formally planned at the time of the Single Entry Point model design.

This first chapter of the Report has introduced the Single Entry Point Model as defined at the beginning of the pilot project. The goals proposed for the testing of this model included verifying the applicability of the model, and revealing the various facets of its potential as well as the points needing improvement. The challenge was twofold, on the one hand to prove it was possible to achieve the goals identified by the Single Entry Point process while on the other, to establish a system of distributing responsibility in such a way as to make the series of functions and procedures specified by the model operational (See diagram in this chapter).

With regard to the goals of service delivery, the following chapters II and III describe the frail elderly eligible for enriched services and reveal the needs such services will have to fill.

CHAPTER II

FORMING THE DEMONSTRATION COHORTS AND DESCRIBING THEIR RESPECTIVE GENERAL PROFILE

In order to collect the information needed to evaluate the Single Entry Point Pilot Project, a group composed of frail elderly was formed in each pilot region. This group is called a "cohort" because the number of persons included is determined by the period of time allotted for its formation, specifically November 1, 1989 to March 31, 1990.

A. FORMATION OF THE DEMONSTRATION COHORTS AS OF MARCH 31, 1990

The demonstration cohorts were composed exclusively of the frail elderly receiving enriched services through the Single Entry Point Project between November 1, 1989 and March 31, 1990 in the two regions: Fredericton and the Péninsule acadienne.

From the beginning of the project, persons whose names appeared on the waiting list were assessed and offered the services available through the Single Entry Point. Subsequently, until March 31, 1990, all frail elders who asked for help were referred to the Single Entry Point and included in the demonstration cohort, if they satisfied the eligibility criteria for enriched social support services.

By March 31, 1990, 60 frail elderly from the Fredericton region and 57 from the Péninsule acadienne region had been admitted to the demonstration cohorts. Of the 60 people in Fredericton, 26 were on nursing home waiting lists at the time the project was implemented, and 34 had been referred to Single Entry Point by different sources. Of the 57 people in the Péninsule acadienne region, 14 were on nursing home waiting lists, and 43 had been referred to Single Point Entry by different sources.

After assessing the persons whose names appeared on waiting lists, the pilot regions used different procedures for admitting clients to the study groups. In the Fredericton region, the eligibility criteria were applied to all frail elders whose service plans were beyond $400 per month. In the Péninsule acadienne region, the eligibility criteria were not applied to persons who, in the opinion of the professionals involved in the project, did not qualify for enriched services. As a result, the size of the two demonstration cohorts was similar and there was notable difference between the two in the average cost per service plan. In order to account for differing applications of the eligibility criteria, the demonstration cohorts were subdivided as follows in the Progress Report (August 27, 1990): two categories for waiting lists (WL - waiting list, NWL - nonwaiting list), and two categories for the cost of the service plan (purchased social support services only): either $399 or less (Group A) or $400 or more (Group B). Table 1 presents the distribution of cases according to subgroups or categories in each region.

Table 1 - Distribution of Frail Elderly in the Demonstration Cohorts
According to Categories and to Region

Cohort	Number of persons		
	Waiting List	None Waiting List	Total
Fredericton			
Group A: $399 and less	16	12*	
Group B: $400 and more	10	22	
Total	26	34	60
Péninsule acadienne			
Group A: $399 and less	11	28	
Group B: $400 and more	3	15	
Total	14	43	57

* This category comprises spouses of clients eligible for the enriched services as well as elderly who had initially a plan of $400 or more and had been modified.

The four subgroups in both regions were then compared with respect to age, sex, language spoken, marital status, living arrangement, need for a caregiver, acceptance of help from a caregiver, type of relationship with caregiver, availability of an additional caregiver, risk of institutionalization if no caregiver were available, and need of caregiver for respite. The results of these comparisons appear in Appendix C of the Progress Report. On the basis of the data available, apparently no real difference was observed between the subgroups in either region regarding the descriptive characteristics considered. Consequently, the general profile presented in the Progress Report applies to all frail elderly in the demonstration cohorts. This profile is presented again in the pages that follow, along with other information contained in the first report.

It should be pointed out that a profile of each cohort was prepared for the purpose of describing the clients currently receiving enriched services, not for the purpose of drawing conclusions with regard to future clients. It should also be mentioned that the evaluation plan for the project (filed and approved in March 1990) did not include objectives for a comparison of the groups in the two regions. The intention was to describe two different situations through the collection of relevant data, according to a uniform method.

WITHDRAWALS - A number of withdrawals occurred between March 31 and September 30, 1990, for which reasons have been recorded. From the Fredericton cohort, three files were closed because the frail elder died; six, because they were admitted to a nursing home; and one, because the frail elder had been transferred to a palliative care unit. From the Péninsule acadienne cohort, one file was closed because the frail elder died; eleven, because they were admitted to a nursing home; two, because they were admitted to hospital; and two because their cases were reviewed. Table 2 shows the number of frail elderly in each of the two cohorts who came to Single Entry Point between November 1, 1989 and March 31, 1990 (first cohorts), the number of those who were still in the demonstration cohorts on September 30, 1990 (current cohorts), and the number of withdrawals between March 31 and September 30.

Table 2 - Number of Frail Elderly in the Demonstration Cohort on Two Different Dates, According to Region

Region	Number of persons March 31, 1990	Number of persons September 30, 1990	Number of of withdrawals
Fredericton	60	50	10
Péninsule acadienne	57	41	16

PERIOD OF PARTICIPATION IN THE COHORTS - A summary of the time spent by the frail elderly in the demonstration cohorts was prepared by comparing the date of entry into the cohorts (date on which the assessment began, as indicated on page 5 of the Assessment Instrument) and September 30, 1990, date on which the second data collection ended, or the date of withdrawal if applicable.

As indicated in Table 3, the 10 withdrawals in the Fredericton cohort had been participating in the project for an average of 6.5 months, the participation period varying between a minimum of 3 and a maximum of 10 months. In the Péninsule acadienne cohort, the 16 withdrawals had been participating in the project for an average of 5.9 months, the participation period varying between a minimum of 2 and a maximum of 11 months.

As to the participation period for the active cases, 50 people in the Fredericton cohort participated in the project for an average of 9.1 months, the participation period varying between a minimum of 7 and a maximum of 11 months. In the Péninsule acadienne cohort, 41 people participated in the project for an average of 8 months, the participation period varying between a minimum of 6 and a maximum of 11 months.

Table 3 - Participation Period for the Frail Elderly in the Demonstration Cohorts According to Region

Cohort	Number of persons	Number of month of participation			
		Minimum	Maximum	Average	Median*
Fredericton					
Withdrawals	10	3	10	6.5	6,5
Active cases	50	7	11	9.1	10,0
Péninsule acadienne					
Withdrawals	16	2	11	5.9	6,0
Active cases	41	6	11	8.0	8,0

* Middle point of the distribution

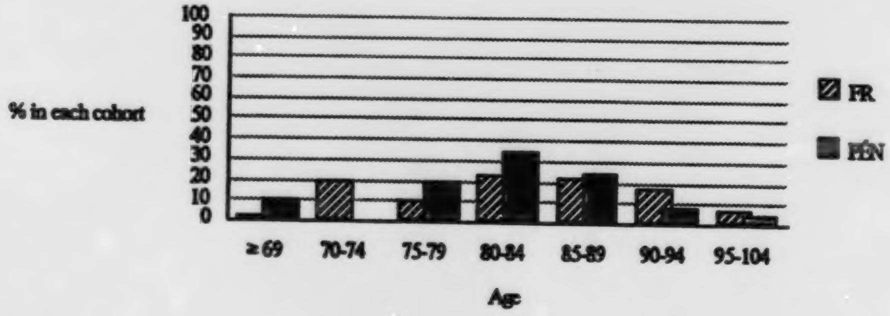
B. GENERAL PROFILE OF THE DEMONSTRATION COHORTS

The information collected in Parts 1B, 2A, and 4E of the form entitled New Brunswick Assessment and Continuing Care Instrument was used to develop a general profile of frail elders in the demonstration cohorts on March 31, 1990. The compilation of this information appears in Appendix G. The resultant profile describes the demonstration cohorts with respect to seven characteristics: age, sex, spoken language and marital status. This profile is completed by some data on four additional elements: type of housing in which the elderly are living, their annual income, their perception of their health status and the approximate number of times they see their doctor over a year.

CHARACTERISTICS OF THE ELDERLY FORMING THE DEMONSTRATION COHORTS AS OF MARCH 31, 1990

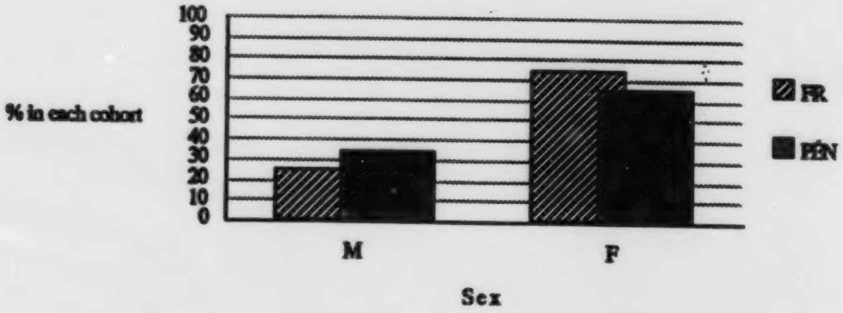
Age on March 31, 1990 - In the Fredericton cohort, the average age was 83.2 years, with a standard deviation of 8.5. According to the usual groupings, 22% of the frail elderly were between 65 and 74 years old; 33%, were between 75 and 84; and 45% were 85 or older. In the Péninsule acadienne, the average age was 82.3 years, with a standard deviation of 7.3. Ten percent were between 65 and 74 years old; 53% were between 75 and 84 years old; and 37% were 85 or older.

GRAPH 1 - COMPOSITION OF THE INITIAL COHORT WITH RESPECT TO AGE



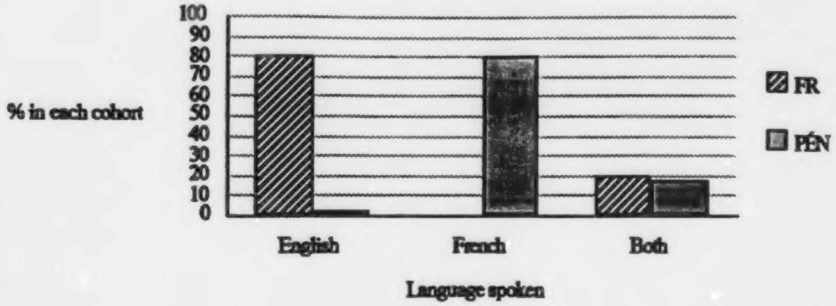
Sex - More than 60% of the people in each cohorts are women.

GRAPH 2 - COMPOSITION OF THE INITIAL COHORT WITH REGARD TO SEX



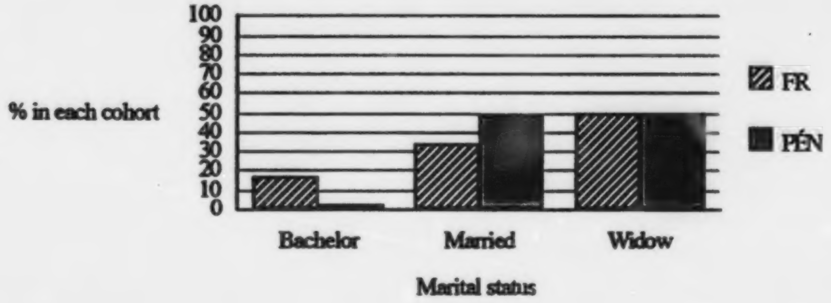
Spoken Language - Most frail elders in the Fredericton cohort were English-speaking while those in the Péninsule acadienne cohort were primarily French-speaking.

GRAPH 3 - COMPOSITION OF INITIAL COHORT WITH RESPECT TO LANGUAGE SPOKEN



Marital Status - Most frail elderly in each cohort did not have a partner. Such was the case for 67% of the people in the Fredericton cohort, and for 59% of those in the Péninsule acadienne cohort..

GRAPH 4 - COMPOSITION OF INITIAL COHORT WITH RESPECT TO MARITAL STATUS

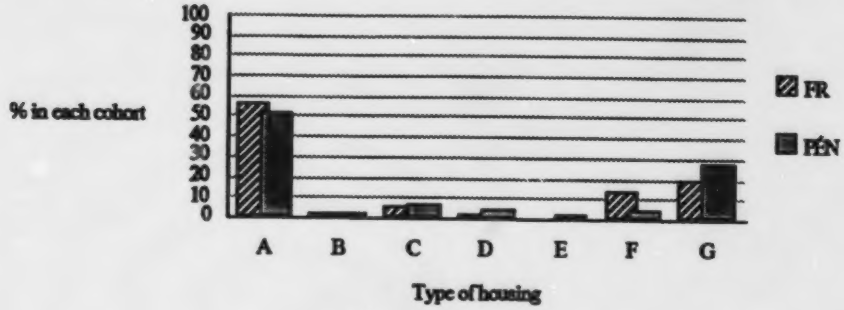


ADDITIONAL INFORMATION ON THE ELDERLY FORMING THE DEMONSTRATION COHORTS AS OF SEPTEMBER 30, 1990

Information recorded at the time of reassessment was gathered in order to offer additional information pertaining to the general profile of the demonstration cohorts. Thus, for the 50 elderly in the Fredericton region and the 41 persons in the Péninsule acadiennne region who were in the demonstration cohort on September 30, 1990, data is available with regard to four additional factors: type of housing, annual income, perception of health status, and the approximate number of times they go to the doctor each year. The graphs 5 to 8 present this information, and the compilation of the data appears in Appendix G.

Type of housing - It was observed that, in each cohort, more than 50% of the frail elderly live in their own homes.

GRAPH 5 - COMPOSITION OF THE CURRENT COHORT WITH RESPECT TO TYPE OF HOUSING



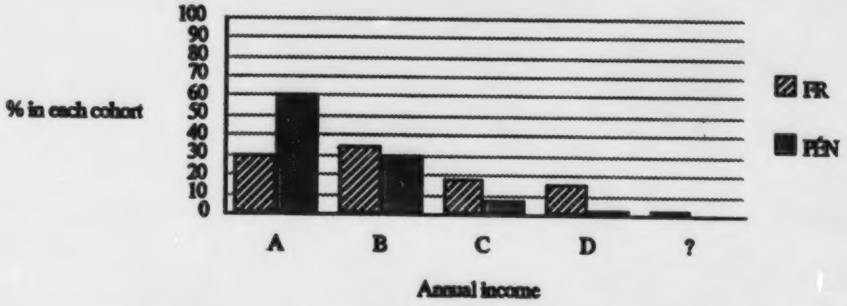
Legend:

A - Lives at home
B - In a rented house
C - In an apartment
D - In a senior citizens residence

E - Room and board
F - Special care homes
G - Other: son's house, hospital, etc.

Annual Income - It was observed that 64% of the frail elderly of the Fredericton cohort have less than $15, 000 of annual income and that 91% of the elderly of the Péninsule acadienne cohort have less than $15,000 of annual income.

GRAPH 6 - COMPOSITION OF THE CURRENT COHORT WITH RESPECT TO ANNUAL INCOME



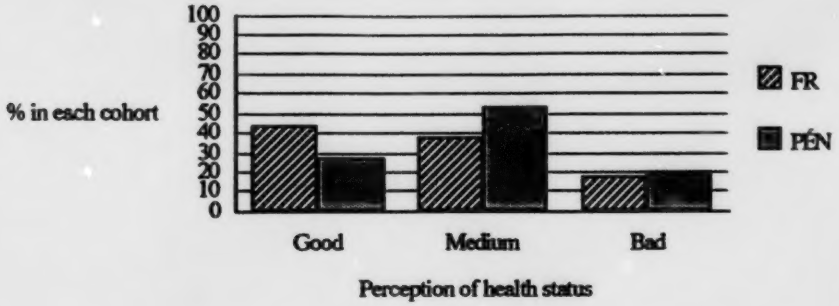
Legend:

A-Less than $10,000
B-From 10,000 to $14,999

C-From $15,000 to $19,999
D-$20,000 or more
? - non divulged

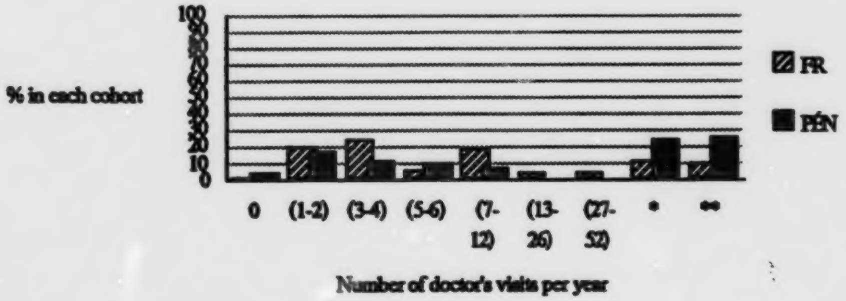
Perception of health status - In both cohorts, few frail elderly perceived their state of health to be poor.

GRAPH 7 - COMPOSITION OF CURRENT COHORT WITH RESPECT TO HEALTH STATUS



Number of doctor's visits - Close to 50% of the frail elderly in the Fredericton cohort and almost 30% of those in the Péninsule acadienne cohort said they went to their doctor from one to four times a year.

GRAPH 8 - COMPOSITION OF CURRENT COHORT
WITH RESPECT TO NUMBER OF DOCTOR'S VISITS PER YEAR



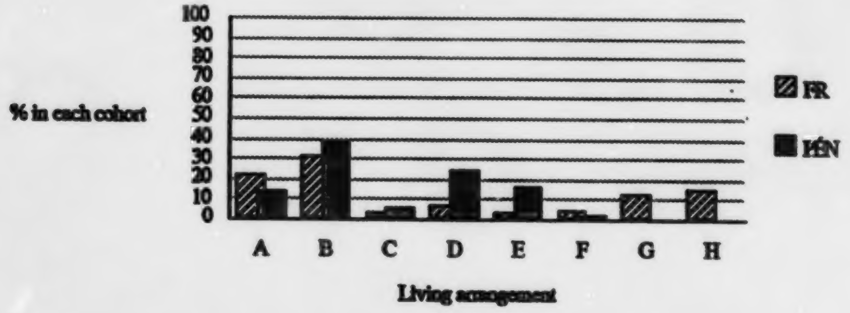
* as needed
** information missing

C. THE NEED FOR SUPPORT AND THE NATURAL SUPPORT NETWORK

The information collected in Parts 1B, 2A, and 4E of the form entitled New Brunswick Assessment and Continuing Care Instrument was used to develop a general profile of frail elders in the demonstration cohorts with reference to their level of need for support and to the capacity of their natural support network to face these needs. The resulting profile describes each demonstration cohort on five elements: living arrangement, needs for a caregiver, availability of a primary caregiver in the natural support network, availability of additional informal caregivers and strength of the natural support network. The compilation of this information appears in Appendix G.

Living Arrangement - More than 30% of the elderly of the Fredericton cohort and nearly 40% of those of the Péninsule acadienne cohort are living with their spouse. Information collected up to March 31, 1990 on living arrangements indicates that almost 15% of the people of the Fredericton cohort live with a hired person and that this living arrangement is not used by the Péninsule acadienne cohort members. On September 30, 1990, the living arrangements had changed little in either cohorts.

GRAPH 9 - COMPOSITION OF THE INITIAL COHORT WITH RESPECT TO LIVING ARRANGEMENT

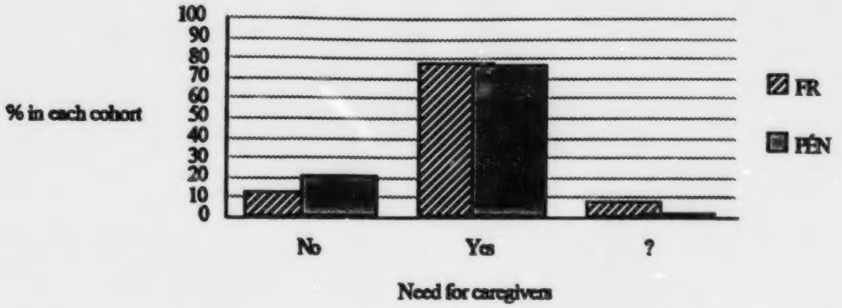


Legend:

A-Lives alone
B-With spouse
C-With spouse and child
D-With daughter
E-With son
F-With other relative
G-With paid help
H-Other: special care home, hospital, etc.

Need for Caregiver - The information collected up to March 31, 1990 on the need for a caregiver indicated that in both cohorts, more than 75% of the frail elderly needed a caregiver if they were to continue living in the community. Such was the professional opinion of social workers who completed assessments. It was observed that up to September 30, 1990, the situation for the Fredericton cohort had not changed. However, information on four additional cases is available: three did not require an informal caregiver and one did. In the Péninsule acadienne cohort, one person who did not need an informal caregiver in March 1990, but did need one in September 1990.

GRAPH 10 - COMPOSITION OF THE INITIAL COHORT WITH RESPECT TO NEED FOR CAREGIVERS

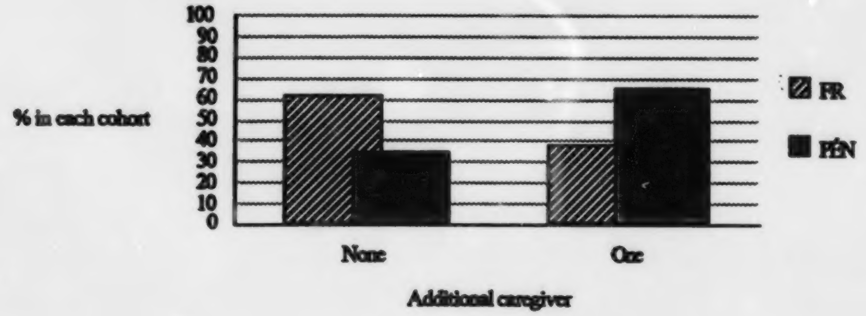


? - answer difficult to interpret as yes or no as well as information missing

Primary caregivers - In the Fredericton cohort, 83% of the frail elderly provided the name of a primary caregiver in their informal network; in the Péninsule acadienne cohort, 97% identified such a caregiver.

Additional caregiver - The information collected up to March 31, 1990 indicated that 38% of persons in the Fredericton cohort identified an additional caregiver, and 65% of the persons in Péninsule acadienne cohort identified one. By September 30, 1990, only 20% of the seniors in the Fredericton cohort gave the name of an additional caregiver; in the Péninsule acadienne cohort, 54% identified an additional informal caregiver.

GRAPH 11 - COMPOSITION OF THE INITIAL COHORT WITH RESPECT TO HAVING OR NOT HAVING AN ADDITIONAL CAREGIVER



Natural support network - It appeared important to group under the heading of "natural support network" the following six elements:

a) living alone ;
b) needing a caregiver;
c) having an informal caregiver;
d) accepting help;
e) having an additional informal caregiver;
f) being at risk of institutionalization if no caregiver is available.

For their own survival and well-being people, and to an even greater extent the frail elderly, need a network of persons who can provide mutual help and who know how to listen. The six facts identified above were derived from a consolidation of the information available on the informal support network in the New Brunswick Assessment and Continuing Care Instrument. A case that answered "yes" to all six questions would indicate a very fragile, even nonexistent, informal network.

Of these facts, only one informs us about the scope of the network. It is important for those frail elderly who need help constantly to be able to count on an additional caregiver who could share the work with the principal caregiver, provide moral support and in so doing prevent burnout, a frequent problem among principal caregivers.

In order to obtain a portrait of the current demonstration cohorts in relation to this category of need, the number of problems experienced by each person in the groups as of September 30, 1990 was added up and the results appear in Table 4 below. The table shows that while 68% of the frail elderly forming the current Fredericton demonstration cohort encountered 3, 4 and 5 of the above-listed problems; 29% of those in the Péninsule acadienne cohort encountered 3 and 4 of them. It is probable that these persons have fragile natural support networks. A clearer picture would be gained if information were available on the ability of the informal caregiver to provide the frail elderly person with the care he/she requires.

Table 4 - Percentage of Frail Elderly in Current Demonstration Cohort Having Encountered a Certain Number of Problems in their Family and Social Environment

Cohort	Number of problems encountered						
	0	1	2	3	4	5	6
	%	%	%	%	%	%	%
Fredericton (Nb=50)	0	6	26	50	10	8	0
Péninsule acadienne (Nb=41)	3	17	51	22	7	0	0

SUMMARY AND CONCLUSION

In conclusion, we present three syntheses. The first exposes how the demonstration cohorts were formed. The second groups significant data with respect to the general profile of the frail elderly in the two demonstration cohorts: The third synthesis presents the need for support of these elderly and the response they get from their informal support network.

FORMATION OF DEMONSTRATION COHORTS - The demonstration cohorts were composed exclusively of the frail elderly receiving enriched services through the Single Entry Point between November 1, 1989 and March 31, 1990 in the two regions: Fredericton and the Péninsule acadienne.

. The pilot regions used different procedures for registering clients in the enriched services group.

  - In the Fredericton regions, the eligibility criteria were applied to all seniors whose service plans were beyond $400 per month.

  - In the Péninsule acadienne region, the eligibility criteria were not applied to clients who, in the opinion of the professionals involved, did not qualify for enriched services.

  - The effect of this different application of eligibility criteria on the general profile presented in this chapter was verified. It did not prove to be significant.

. Between March 31 and September 30, 1990 (dates selected for evaluation purposes), a certain number of withdrawals occurred in one or the other of the demonstration cohorts.

- Of the 60 cases in the Fredericton cohort, three were closed because the client died, six because they were admitted to a nursing home, and one because the client was transferred to a palliative care unit.

- Of the 57 cases in the Péninsule acadienne cohort, one was closed because the client died, 11 because they were admitted to a nursing home, two because they were admitted to hospital, and two because their cases were reviewed.

- On September 30, 1990, the Fredericton present demonstration cohort groups 50 frail elderly and the Péninsule acadienne present demonstration cohort groups 41 frail elderly.

TIME OF PARTICIPATION IN THE COHORTS

. The 10 cases that were closed in the Fredericton cohort have participated to the pilot project for an average of 6,5 months, the participation time varying from a minimum of 3 months to a maximum of 10 months.

. The 16 cases that were closed in the Péninsule acadienne cohort have participated to the pilot project for an average of 5,9 months, the participation time varying from a minimum of 2 months to a maximum of 11 months.

. On September 30, 1991, the 50 persons in the present Fredericton cohort had been participating for an average of 9.1 months in the project, the participation period varying between a minimum of 7 and a maximum of 11 months.

. On September 30, 1991, the 41 persons in the present Péninsule acadienne cohort had been participating for an average of 8 months in the project, the participation period varying between a minimum of 6 and a maximum of 11 months.

GENERAL CHARACTERISTICS OF THE FRAIL ELDERLY IN THE DEMONSTRATION COHORTS- The characteristics used to describe each demonstration cohort are as follows: age, sex, language spoken, marital status, type of housing, annual income, perception of health status, and approximate number of doctor's visits per year.

. The average age of persons making up the Fredericton cohort is 83.2, and for the Péninsule acadienne cohort, 82.3.

. The majority are women: 75% in the case of the Fredericton cohort and 63% in the Péninsule acadienne cohort.

. In the Fredericton cohort, 80% of frail elderly persons are English-speaking; in the Péninsule acadienne cohort, 86% are French-speaking.

. A large number of frail elderly in the Fredericton cohort live alone or with a hired companion (22%); in the Péninsule acadienne cohort, 12% live alone and none live with a hired companion.

- In both cohorts, over 50% of seniors live in their own homes.
- In the Fredericton cohort, 64% have an annual household income of less than $15,000; the same is true of 91% of the frail elderly persons in the Péninsule acadienne cohort.
- Most of cohort members perceive their health to be good.
- Nearly 50% of frail elderly in the Fredericton cohort say they go to the doctor between one and four times a year; nearly 30% of those in the Péninsule acadienne cohort say the same thing.

NEED FOR SUPPORT AND RESPONSE OF INFORMAL SUPPORT NETWORK - Five elements were selected to describe the need for support and the response of the informal support network to this need: living arrangement, need for a caregiver, availability of a primary caregiver in the senior's informal network, availability of additional caregivers in this network, and solidity of the informal support network.

- Living arrangement: 22% of frail elderly persons in the Fredericton cohort live alone or with a hired companion; 13% of those in the Péninsule acadienne cohort live alone and none live with a hired companion.
- Need for a caregiver: in both cohorts, more than 75% need a caregiver in order to continue living outside an institution.
- Availability of primary caregiver: in both cohorts, the great majority (83% and 97%) identified a primary caregiver.
- Availability of additional caregiver: most seniors in the Fredericton cohort were unable to identify an additional caregiver; such was not the case for the Péninsule acadienne cohort.
- The family and social network appears to be fragile for 68% of the persons in the Fredericton cohort and 29% of those in the Péninsule acadienne cohort.

This chapter has presented the general characteristics of the elderly forming the demonstration cohorts, their need for a caregiver in order to continue living at home or in a community setting and the capacity of their natural support network to tend to their need of support.

The following chapter presents a more in depth study of the needs particularly in relation with daily living and with health. Such a study proposes some explanations to the need of support described in this chapter.

CHAPTER III

PROFILE OF NEEDS OF DEMONSTRATION COHORTS

The profile of needs of the demonstration cohorts results from the compilation of the assessment made by the social workers and the health workers. The professionals expressed their assessment or reported the observations or judgments made by the elderly by indicating either the degree of difficulty the client had or the degree of help they needed to manage, despite any problems or limitations observed.

This assessment is said to be multidisciplinary because it includes a social assessment as well as a health assessment. Its goal is to determine the seniors' needs in six domains that, while distinct, are interrelated in terms of their reciprocal effects.

1) Physical health status - Seventeen elements were used to define and assess the physical health. The information gathered dealt with communication (vision, hearing, expression, comprehension), personal organization (medications, sleep, diet), and the main bodily functions (respiration, circulation, elimination).
2) Mobility - Limited muscle strength, impaired sensation, impaired coordination, rigidity, and impaired balance are some of the physical handicaps that may affect the elderly and reduce their mobility both inside and outside the home.
3) Activities of daily living - Eating, dressing, grooming, etc are activities considered essential to individual survival and well-being. Preserving one's autonomy means preserving a sufficiently high level of physical and mental health to be able to carry out these daily living activities by oneself.
4) Instrumental activities of daily living - These are a series of activities that must be performed on a daily basis for a household to function smoothly: for example, shopping, meal preparation, housecleaning, and banking.
5) Mental health status - Mental health is the mainstay of individual autonomy. Awareness, orientation in time and space, memory, and judgment/decision-making ability were the factors used to define mental health in this context.
6) Psychosocial status - The degree to which participation in family and social life is satisfactory and pleasant depends on whether the senior is overwhelmed or not by problems such as anxiety, depression, and tendencies toward suspiciousness or aggression. A set of seventeen elements were examined under this heading.

To illustrate the needs of each demonstration cohort, each of the six categories was looked at from two complementary standpoints: the cohorts' profile observed up to March 31, 1990 and the changes observed from April 1 to September 30, 1990.

The status of the demonstration cohorts up to March 31, 1990, is the results of the compilation of the judgments recorded in the Assessment Summary section (Part VII) New Brunswick Assessment and Continuing Care Instrument. For each cohort, the principal information provided by this profile is the percentage of persons in each pilot cohort with a given functional or health status at the time of assessment. The status of the frail elder is expressed on a four-point scale that can be read, depending on the element in question, along one or both of two continuums: severity of the problem and degree of assistance required.

POINT ON THE SCALE AND DEFINITION

1 No problem or alteration
and/or
Total ability to manage by oneself

2 Some problem or alteration
and/or
Ability to manage with some assistance

3 Severe problem or alteration
and/or
Ability to manage with regular supervision

4 Very severe problem or alteration
and/or
Inability to manage by oneself, need for constant supervision

The changes observed result from information gathered during the periodic reassessment required under the Single Entry Point model. This information is compared to the information available for the same individuals as they were part of the initial cohorts. Results of the compilation appear in Appendix H under the headings "initial cohort" and "present cohort". The changes noted in the needs profiles are indicated below.

FIRST DOMAIN: PHYSICAL HEALTH STATUS

The cohorts' profiles observed up to March 31, 1990 - Graph 12 below indicates that the main health problems of the frail elderly are the following:

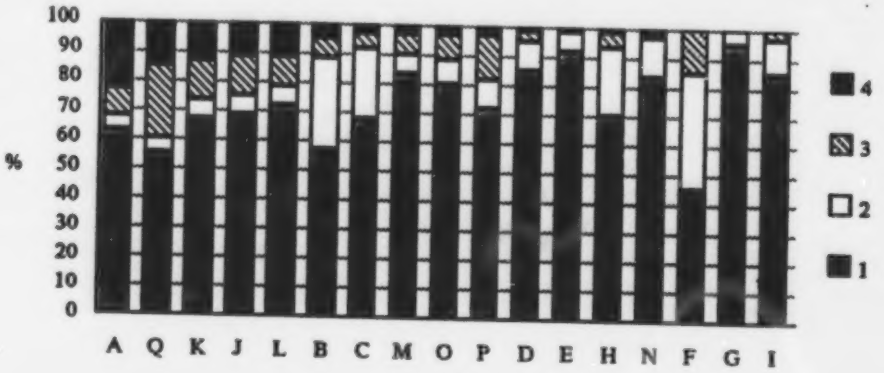
- Management of medication - 32% of the elder in the Fredericton cohort and 52% of those in the Péninsule acadienne cohort have severe or very severe problems (column A, points 3 and 4 on scale). These persons could not cope without supervision or constant assistance.
- Physical functioning - 40% of the elderly in the Fredericton cohort and 38% of those in the Péninsule acadienne cohort have severe or very severe problems (column Q, points 3 and 4 on

the scale). Physical problems such as impaired muscle strength, impaired sensation, impaired coordination, rigidity, or impaired balance may handicap these frail elderly.

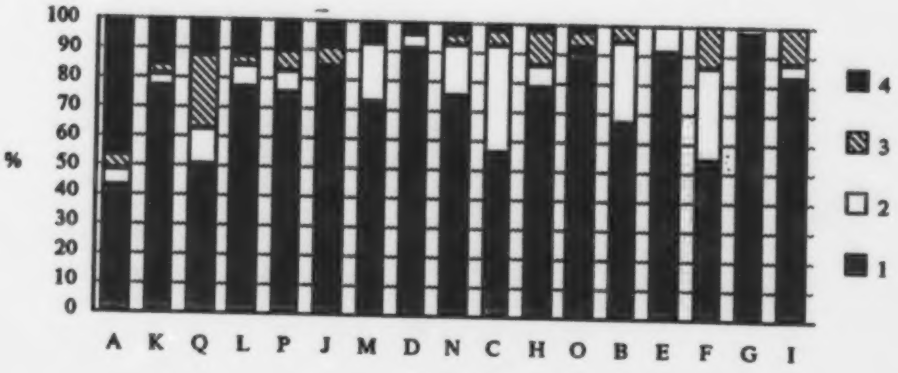
- Urinary and bowel management - 27% and 22% of the elderly in the Fredericton cohort have severe or very severe problems in this domain (column K and L, points 3 and 4 on the scale); 19% and 16% of the elderly in the Péninsule acadienne cohort have similar problems.
- Tissue and skin management - 25% of the elderly in the Fredericton cohort and 16% of those in the Péninsule acadienne cohort have severe and very severe problems (column J, points 3 and 4).

GRAPH 12 - PHYSICAL HEALTH STATUS

FREDERICTON COHORT



PÉNINSULE ACADIENNE COHORT



Legend:

A - Management of Medication
D - Expression-Communication
G - Oral Hygiene
J - Tissue-Skin Management
M - Pain Management
P - Circulation

B - Vision
E - Receptive Language
H - Diet
K - Urinary Management
N - Sleep
Q.- Physical functioning

C - Hearing
F - Dentition
I - Hydration
L - Bowel Management
O - Respiration

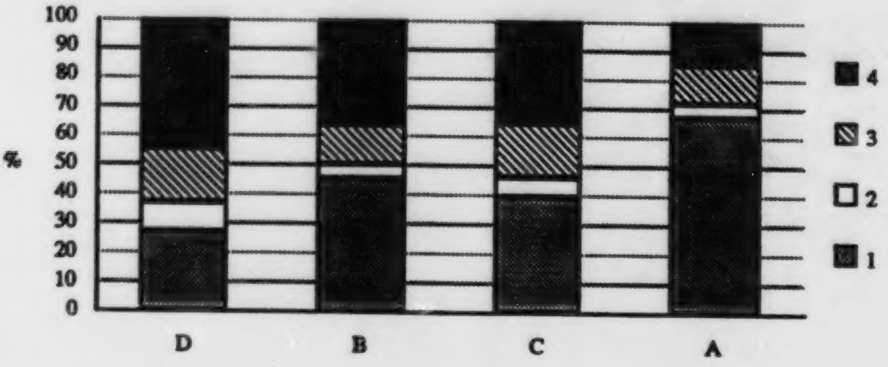
Changes observed up to September 30, 1990 - The incidence of problems with the management of medication was 14% higher in the Fredericton cohort and 15% higher in the Péninsule acadienne cohort than it was up to March 31, 1990. As for tissue-skin management, there was an improvement in the Péninsule acadienne cohort where 12% fewer people reported Level 3 or 4 problems. The situation with regard to bowel and urinary management and pain management was stable in both cohorts. A slow progression in problems and handicaps related to physical functions was observed: the number of people reporting Level 3 or 4 problems was 9% higher in the Fredericton cohort and 7% higher in the Péninsule acadienne cohort.

SECOND DOMAIN: MOBILITY

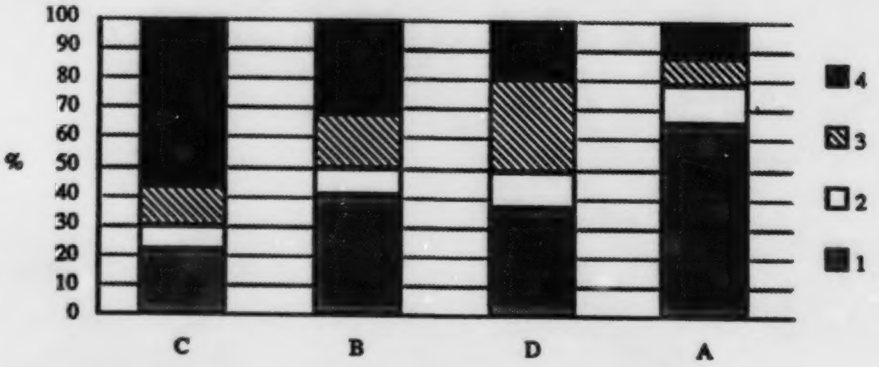
The cohorts' profiles observed up to March 31, 1990 - In both cohorts, 50% or more of the frail elderly had severe or very severe problems with regard to outdoor mobility, stairs, ramps, and transportation (Graph 13: columns B, C, and D - points 3 and 4 on scale).

GRAPH 13 - MOBILITY

FREDERICTON COHORT



PÉNINSULE ACADIENNE COHORT



Legend:

A - Indoor Mobility	C - Stairs-Ramps
B - Outdoor Mobility	D - Transportation

Changes observed up to September 30, 1990 - In each of the two cohorts, more elderly (14% higher) reported level 3 or 4 problems with regard to stairs and ramps. In September the number of persons in the Fredericton cohort reporting Level 3 or 4 problems with outdoor mobility was 14% higher, than in March, 1990. The number of persons in the Péninsule acadienne cohort reporting Level 3 or 4 problems with regard to the inability to get around in a car was 19% higher in September than March 31, 1990. However, it should be noted that during the interviews, a few frail elders from the Péninsule acadienne said they had regained some degree of indoor mobility through the use of specialized equipment.

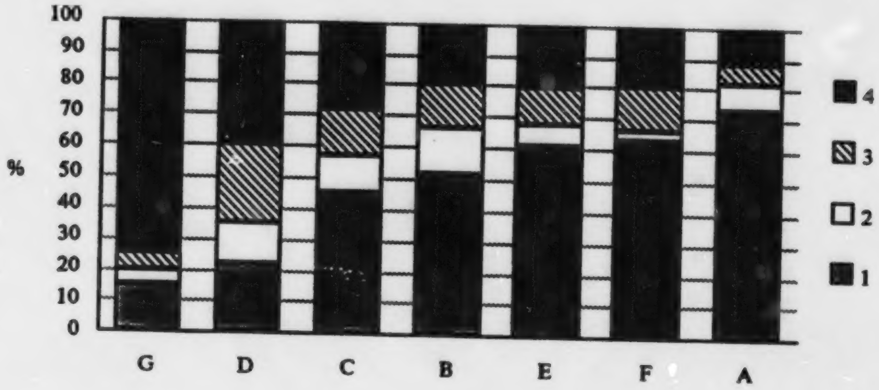
THIRD DOMAIN: ACTIVITIES OF DAILY LIVING

The cohorts' profile observed up to March 31, 1990 - Graph 14 shows that the bathing and foot care activities of daily living caused severe or very severe problems for the largest number of seniors in the cohorts were (columns D and G, points 3 and 4). In the Fredericton cohort, over 60% had problems with bathing and 80% with foot care. In the Péninsule acadienne cohort, 76% had problems with bathing and 53% with foot care. Dressing, grooming, toileting, and moving around -- getting up, sitting down, etc. -- were also severe or very severe problems (columns B, C, E, and F, points 3 and 4) for 25% to 40% of the seniors in the cohorts.

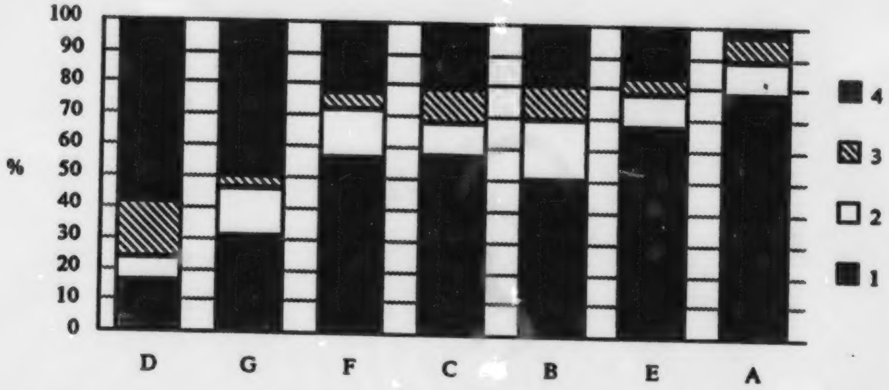
Changes observed up to September 30, 1990 - The same activities of daily living were still causing the most significant problem for the largest number of persons in the cohort. Certain changes can be noted, however. In the Fredericton cohort, the number of persons reporting level 3 or 4 problems with respect to bathing was 12% higher than it had been in March 31, 1990; it was 11% higher also for the elderly of the Péninsule acadienne cohort. At the time of reassessment, it was also noted that nearly half of the frail elderly of the cohorts are now reporting level 3 or 4 problems with grooming: 48% in the Fredericton cohort, 47% in the Péninsule acadienne cohort.

GRAPH 14 - ACTIVITIES OF DAILY LIVING

FREDERICTON COHORT



PÉNINSULE ACADIENNE COHORT



Legend:

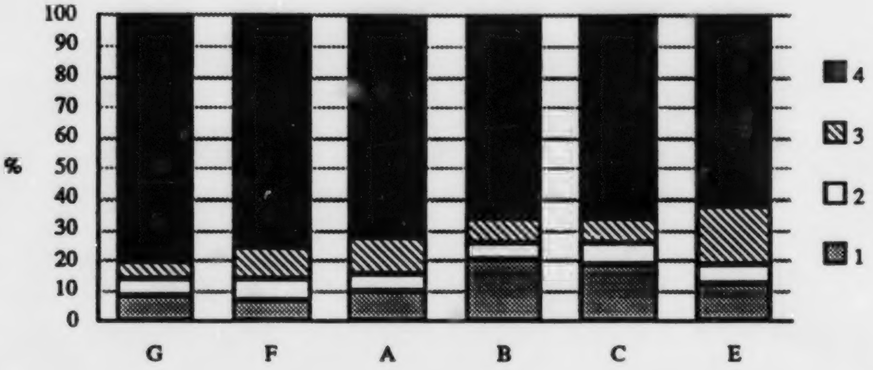
A - Eating
B - Dressing
C - Grooming
D - Bathing
E - Toileting
F - Transfer
G - Foot Care

FOURTH DOMAIN: INSTRUMENTAL ACTIVITIES OF DAILY LIVING

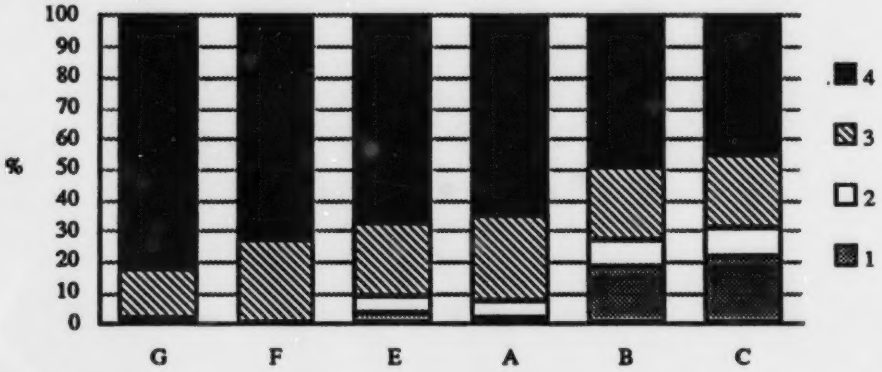
The cohorts' profile observed up to March 31, 1990 - As Graph 15 indicates, all instrumental activities of daily living were difficult for the frail elderly in both cohorts. The percentage of people reporting severe or very severe problems with shopping, banking, money management, meal preparation, housecleaning, and repairs/yard work was 70% or more (columns A, B, C, E, F, and G; points 3 and 4 on scale).

GRAPH 15 - INSTRUMENTAL ACTIVITIES OF DAILY LIVING

FREDERICTON COHORT



PÉNINSULE ACADIENNE COHORT



Legend:

A - Shopping	E - Meal Preparation
B - Banking	F - Housecleaning
C - Money Management	G - Repairs-Yard
D - Use of Telephone (information not available)	

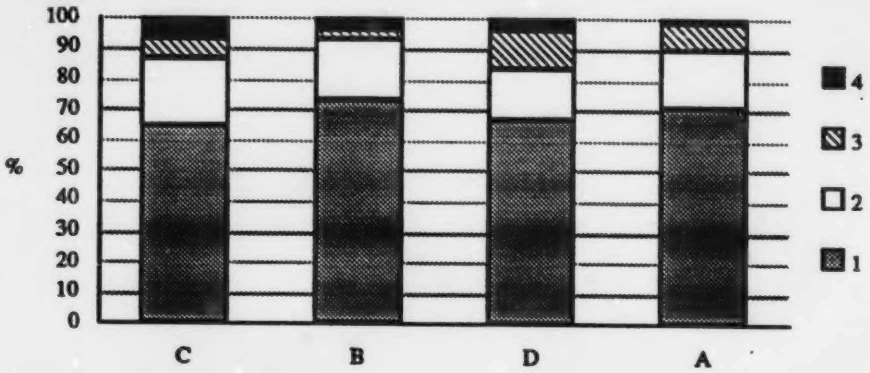
Changes observed up to September 30, 1990 -.The proportion of persons reporting level 3 or 4 problems with regard to shopping, banking, and housecleaning was increased by 9%, 9%, and 11% respectively over March 31, 1990. The number of persons in the Péninsule acadienne cohort reporting level 3 or 4 problems with respect to banking, money management, and meal preparation increased by 14%, 24%, and 13% respectively over March 31, 1990.

FIFTH DOMAIN: MENTAL HEALTH STATUS

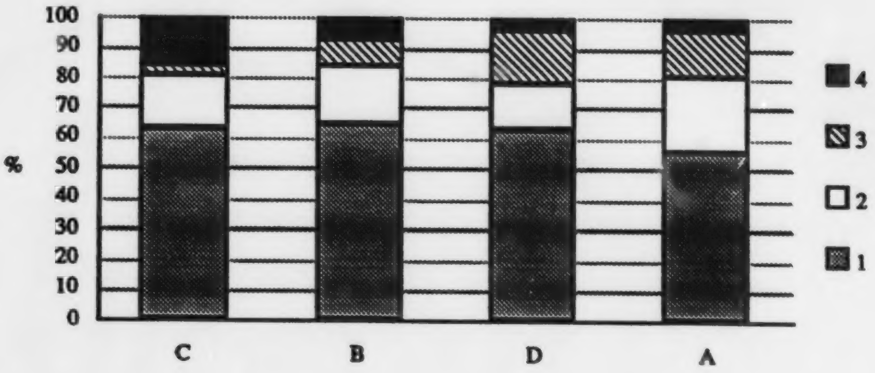
The cohorts' profile observed up to March 31, 1990 - There were severe or very severe problems in both cohorts with regard to judgment and decisions - approximately 20% (Graph 16: column D, points 3 and 4 on scale).

GRAPH 16 - MENTAL HEALTH STATUS

FREDERICTON COHORT



PÉNINSULE ACADIENNE



Legend:

A - Awareness
B - Orientation
C - Memory
D - Judgment-Decision

Changes observed up to September 30, 1990 - The proportion of frail elderly in the Fredericton cohort for whom level 3 or 4 problems were reported with regard to orientation, memory, and judgment-decision was increased by approximately 10% over March 31, 1990. The situation in the Péninsule acadienne cohort can be considered stable.

SIXTH DOMAIN: PSYCHOSOCIAL STATUS

In preparing the psychosocial status profile, a three-point scale was used to illustrate the situation more clearly:

POINT ON THE SCALE AND DEFINITION

1 No problem; able to act without supervision, no intervention necessary

2 Existence of problem; need regular supervision, regular intervention required

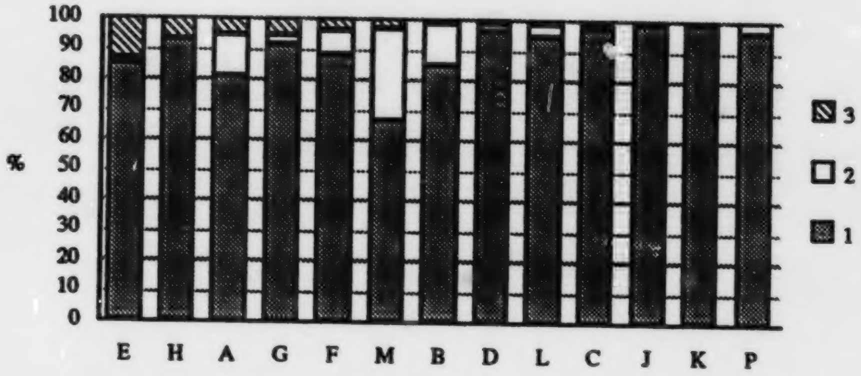
3 Existence of problem; needs constant supervision, frequent interventions required.

The cohorts' profile observed up to March 31, 1990 - Graph 17 shows that 20% to 30% of the Fredericton cohort had problems with regard to anxiety, depression, agitation, social interaction, and leisure (columns A, B, E, and M; points 2 and 3 on the scale). In the Péninsule acadienne cohort, 50% had problem,s with regard to social interaction and leisure while 20% suffered from anxiety, depression and agitation.

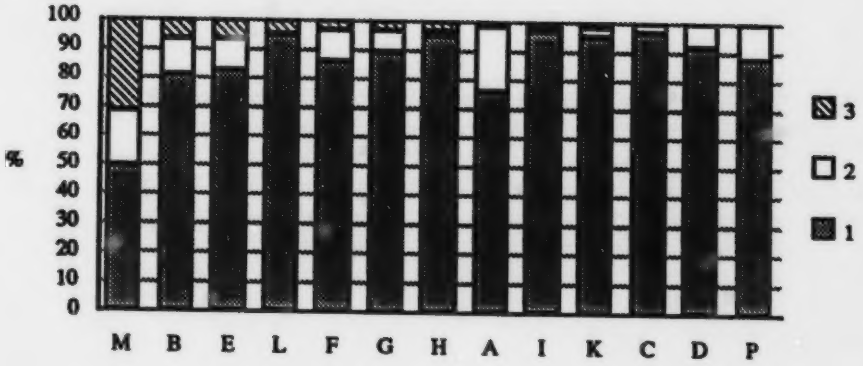
Changes observed up to September 30, 1990 - The situation was almost unchanged at the time of reassessment. Agitation, aggression, and anxiety constituted severe problems for 12 to 24% of the persons making up the Fredericton present cohort. In the Péninsule acadienne, lack of social interaction was reported as a serious problem by 56% of the persons in the cohort; depression, formerly seen as a serious problem by 17% of the participants, dropped to a level of 9%.

GRAPH 17 - PSYCHOSOCIAL STATUS

FREDERICTON COHORT



PÉNINSULE ACADIENNE COHORT



Legend:

A - Anxiety
B - Depression
C - Suicide Ideation
D - Suspiciousness-Paranoia
E - Agitation
F - Aggression
G - Hoarding-Rummaging
H - Wandering
I - Indiscriminant Ingestion*
J - Substance Abuse**
K - Smoking
L - Sexuality
M - Social Interaction-Leisure
N - Values-Belief-Spirituality***
O - Ineffective Coping***
P - Vulnerability
Q - Potential Injury***

* In the Fredericton cohort, no client expressed a problem with this aspect.
** Information not reported in the Péninsule acadienne cohort.
*** Information not reported.

SUMMARY AND CONCLUSION

In the final analysis, we prepared a table to describe the extent of the problems of everyday living identified by the frail elderly in both cohorts. Table 5 presents the number of severe and very severe problems encountered by the seniors in the Fredericton and Péninsule acadienne cohorts in the categories of instrumental activities of daily living (IADL), activities of daily living (ADL), and mobility. We can establish that 71% of the seniors in each cohort were unable to perform at least five of the seven instrumental activities of daily living without regular or constant assistance. Further that 48% of the Fredericton cohort, 38% of the Péninsule acadienne cohort needed regular or constant assistance for at least three of the seven activities of daily living and over 60% of the people in each cohort had problems getting around without assistance.

Table 5 : Number of Severe and Very Severe Problems in the Instrumental Activities of Daily Living (IADL), Activities of Daily Living (ADL) and Mobility.

Number of problems	Cohort of Fredericton			Cohort of the Pén. acad.		
	IADL	ADL	Mobility	IADL	ADL	Mobility
	%	%	%	%	%	%
None	7	10	35	0	18	29
One	2	25	10	0	20	20
Two	8	17	8	0	25	21
Three	3	8	18	11	11	16
Four	8	10	28	18	2	14
Five	3	8		7	13	
Six	68	12		33	7	
Seven	0	10		31	5	

IADL: Shopping, banking, money management, use of telephone, meal preparation, house cleaning, house repairs and yard tidying.

ADL: Eating, dressing, grooming, bathing, toileting, transferring (getting up, sitting, lying down, etc.), foot care.

MOBILITY: Indoor mobility, outdoor mobility, managing stairs and ramps and using transportation.

In short, the profile of needs described in this section reveals that the greatest needs are in instrumental activities of daily living, in particular, personal care activities such as bathing, foot care, and dressing. From a problem-solving standpoint, it can be assumed that this situation can likely be explained by the problems reported with physical health, mental health, and psychosocial status.

Therefore, the frail elderly need almost constant assistance making the informal support network all the more important. However, as we found in Chapter II, the network is fragile for a great many of these people (68% in the Fredericton cohort and 29% in that of the Péninsule acadienne). The following chapter presents a portrait of the people who assume the role of caregiver in this informal support network.

CHAPTER IV

INFORMAL CAREGIVERS

In order to continue living in their own home or in normal family and social environments, over 75% of frail elders in both demonstration cohorts need someone to help them out on a regular basis (see Chapter II, p. X). The objective of this chapter is to gather the data available on persons known as informal caregivers.

A. INFORMATION OBTAINED FROM THE MULTIDISCIPLINARY ASSESSMENT

The New Brunswick Assessment and Continuing Care Instrument used for multidisciplinary assessment contains a few items dealing with the informal-network caregiver. In section 2D, the primary caregiver is identified and section 4E provides information on their relationship with the elderly person, the tasks he/she performs and the care he/she provides. It includes the social worker's opinion regarding the informal caregiver's ability to provide care; a description of his/her availability, motivation and physical and emotional capacity; as well as, it provides information on the limitations faced by the caregiver. Section 4E also has space for similar data on the additional informal caregiver, if such a person is available among the elderly personal friends and family. Lastly, the Caregiver Strain Questionnaire is completed in cases where this is deemed useful. However, Part VII of the NBACCI form, entitled Assessment Summary, has no section summarizing the situation with respect to the informal caregiver.

RELATIONSHIP WITH CAREGIVER - Table 6 shows that, for a large number of frail elderly in the Fredericton cohort (28%), the spouse is identified as the informal caregiver. This is also the case for a large number of frail elderly in the Péninsule acadienne cohort (17%). The exact age of the informal caregivers is not known, but since close to 80% of the persons making up the demonstration cohort are 75 or older, it can be assumed that many of the caregivers are also elderly.

Table 6 also reveals that a greater number of frail elderly in the Péninsule acadienne demonstration cohort identified one of their children (usually a daughter) as their informal caregiver.

Table 6 - Relationship with Informal Caregiver

Relationship	Fredericton Cohort (N=50)	Péninsule acadienne Cohort (N=41)
	%	%
Daughter	18	52
Son	18	17
Souse	28	17
Relatives	22	5
Friend	2	7
No caregiver available	8	2
No caregiver required	4	0

ABILITY OF PRIMARY CAREGIVER TO PROVIDE CARE - Section 4E of the New Brunswick Assessment and Continuing Care Instrument form requests the social worker to comment on the ability of the primary caregiver to care for the frail senior. The social workers used this space to note whether the primary caregiver worked outside the home and to comment on his/her degree of availability, health, and motivation, as well as the actual assistance provided. They also mentioned whether the primary caregiver was exhausted and required assistance or relief.

Since each professional involved in the assessment determined the significant elements that should be noted for each case assessed, all the above elements were not noted systematically for each informal caregiver in the group studied. As a result, it is not possible for the time being to offer a global characterization on the ability of the informal caregivers to care for the frail elder.

B. INFORMATION OBTAINED FROM INTERVIEWS WITH INFORMAL CAREGIVERS

Interviews were conducted with a number of persons taking care of elderly persons receiving Single Entry Point enriched services. In the Fredericton cohort, 24 caregivers answered the interview questions, and 25 in the Péninsule acadienne cohort. Verification of the relationship between the caregivers interviewed and the frail seniors for whom they were caring revealed a satisfactory correspondence with the distribution observed in Table 6 above. The verification of the distribution of relationships and a compilation of the interview answers are contained in Appendix C.

AMOUNT OF TIME SPENT PROVIDING CARE - The informal caregivers interviewed were composed of persons whom the frail elder had designated as their informal caregiver. No other criteria was used as a basis for including or excluding individuals. One person in the Fredericton cohort did not designate an informal caregiver. It is also necessary to keep in mind the differences already observed (Chapter II) in the two pilot regions with regard to living arrangements, particularly the option of living alone: in the Fredericton cohort, 22% of the frail elderly in the demonstration cohort lived alone; in the Péninsule acadienne, 12% lived alone.

Those are a few factors that must be taken into consideration when reading the following table, which shows the amount of time informal caregivers interviewed said they spent helping the elderly person for whom they cared. Most informal caregivers from the Fredericton cohort (67%) devoted 15 hours or less per week to the frail elder whom they look after; in the Péninsule acadienne cohort, most (66%) spent 26 hours or more with the frail elder.

Table 7 - Time Spent by Informal Caregivers Looking After the Frail Elderly

Number of hours	Fredericton Cohort		Péninsule acadienne Cohort	
	N=24	%	N=25	%
5 hours or less per week	9	38	0	0
6 to 15 hours per week	7	29	2	8
16 to 25 hours per week	2	8	2	8
26 to 35 hours per week	0	0	3	12
Almost all the time	3	13	7	28
24 hours/7 days per week	2	8	7	28
No answer	1	4	4	16

TASKS PERFORMED - In order to find out what caregivers do when they take care of the frail elder, the following open-ended question was asked during the interview: "What exactly do you do to help?"

As Table 8 shows, close to 30% of informal caregivers help the frail elderly with personal care. This is part of the activities of daily living and includes tasks such as help with bathing, grooming and dressing, help with transferring, etc.

The next seven tasks have to do with instrumental activities of daily living. The large number of caregivers who said they prepared meals, did housecleaning, ran errands, etc., corresponds with the profile of needs developed for the frail elderly in both demonstration cohorts, profile which indicated high needs in that domain.

With respect to the physical health of the frail elderly, a few informal caregivers said they gave medications and looked after medical appointments. In the categories of mental health and psychosocial status, several caregivers provided supervision and participated in social interactions with the elders they looked after.

In short, informal caregivers perform a very wide range of tasks. These tasks are related to the profile of needs traced for the elderly of both demonstration cohorts.

Table 8 - Tasks Performed by Informal Caregivers

Tasks performed (Open question to caregivers)	Fredericton Cohort		Péninsule acadienne Cohort	
	N=24	%	N=25	%
Help with personal care	7	29	10	40
Preparing meals	7	29	17	68
Doing housework	6	25	13	52
Running errands	7	29	9	36
Shopping	8	33	1	4
Doing repairs and yard work	3	13	0	0
Banking and managing budget	14	58	0	0
Being an escort	4	17	2	8
Helping with medications	2	8	4	16
Taking care of medical appointments	2	8	1	4
Watching over	1	4	8	32
Helping with social interactions	13	54	8	32
Giving moral support	1	4	1	4

Analysis of the answers to the other interview questions reveals that informal caregivers agreed with the objectives of the Single Entry Point project, felt their experience with the program had been positive, and were very satisfied with the services received. These questions are dealt with in detail in Chapter X of this report

SUMMARY AND CONCLUSION

The responses to the interviews provide a clear picture of informal caregivers, the persons on whom a vast majority of frail elderly in the demonstration cohort rely. As can be seen, they do not form a homogeneous group that can be described in a few broad strokes.

Two important pieces of data will be used here in order to describe the cohorts studied: ability to count on spouse or son/daughter as primary caregiver and ability to count on a certain amount of time or assistance each week.

- With regard to these factors, 64% of the frail elderly persons in the Fredericton cohort said they could count on an immediate family member, particularly their spouse (28%), as primary caregiver, and 21% said they could depend on assistance being available at all times.
- For the Péninsule acadienne cohort, 86% of seniors said they could count on an immediate family member, especially their daughter (52%), as primary caregiver, and 56% had access to assistance around the clock.

The informal caregivers and frail elderly themselves have to cope with numerous problems. These problems often lead to changes in the way things are done or the way in which available family resources are used. A pool of expertise exists based on research and practical experience in solving such problems at every stage of life. Persons with this expertise could be called upon to play an important role by providing individual or group education designed to maintain or enhance the ability of individuals to cope with problems related to methods and resources.

The services offered under the Single Entry Point model are linked not only with the needs of the frail senior, but also the characteristics of the primary caregiver in the informal support network. The data contained in this chapter can therefore serve to partially justify the types of services offered and the costs of services for a given cohort.

CHAPTER V

ANALYSIS OF OTHER SINGLE ENTRY POINT CLIENTELES

The aim of this chapter is to present a set of data describing other Single Entry Point clienteles. It presents some characteristics of these clienteles resulting from a study of two groups of cases chosen to represent two categories of files: new cases opened during the pilot project, and active cases from the Community based Services for Seniors program. The elderly in the latter group were selected on the basis of a need for re-assessment: annual reassessment assigned through RPSS system and reassessment resulting from a request by the elderly person or the intervention of a social worker.

To represent new cases (i.e., clients who were not open at the time of intake), 60 new intakes were selected from the Fredericton region and 49 from the Péninsule acadienne region. The intakes took place in June or May 1990.

To represent active cases, a group of cases reassessed beginning on August 27, 1990 were included in the study. The files subject to annual reassessment were represented by 33 cases from the Fredericton region automatically flagged by the RPSS information system, and 25 from the Péninsule acadienne region. The files reassessed as a result of a change in the client's situation were represented by 27 cases from the Fredericton region and 25 from the Péninsule acadienne region.

A. PERCENTAGE OF CASES ELIGIBLE FOR ENRICHED SERVICES - All the cases chosen for this study were registered in accordance with the Single Entry Point procedures. The data normally available after the multidisciplinary assessment are available on all the cases and have been compiled (see Appendices G and H).

Eligibility for enriched services was determined in both pilot regions according to the usual procedure (see Section A of Chapter II). The results appear in the following table: 12% of new cases in the Fredericton region and 16% of those in the Péninsule acadienne region were determined eligible for enriched services. Of the reassessed cases either the ones automatically flagged by the RPSS information system or the ones reassessed as a result of a change in the client's situation, the percentage of cases eligible for enriched services ranged from 0% to 26%.

It should be noted that in the case of the reassessments the data is based on small groups chosen over a short period of time (one month). Due to the limitations imposed by the time frame of the evaluation, information was not available for a period greater than 12 or 18 months. Consequently, the results observed here are valid only as a guide and are not reliable for forecasting purposes.

Table 9: Distribution of Cases Following Assessment

Category	Region and clientele											
	Fredericton						Péninsule acadienne					
	New cases		Reassessments				New cases		Reassessments			
			System		SW/Client				System		SW/Client	
	N	%	N	%	N	%	N	%	N	%	N	%
Regular Services	51	85	25	76	20	74	37	76	24	96	23	92
Enriched services	7	12	8	24	7	26	8	16	0	0	1	4
Nursing Home Waiting List	2	3	0	0	0	0	4	8	1	4	1	4
Total	60	100	33	100	27	100	49	100	25	100	25	100

B. REFERRAL SOURCE - At intake, the elderly person is asked who referred him/her to the Single Entry Point program. In the Fredericton region, an analysis of referral sources for persons forming the group of new cases shows that there were four main sources of referral. They are ranked in order of importance: hospital or other institution, family, friends, and a social agency. A similar study of intakes in the Péninsule acadienne region revealed that another social agency was the main referral source and that a large number of elderly said they came to the Single Entry Point system on their own.

C. DESCRIPTION OF THE CLIENTELES UNDER STUDY - In the following three studies, we shall compare the new cases and the reassessed cases with frail elders in the current demonstration cohort receiving enriched services from the start of the pilot project. This cohort was composed of 50 frail elderly from the Fredericton region and 41 from the Péninsule acadienne region.

The first study deals with a basic piece of demographic data, the age distribution in each group. The second and third studies will establish comparisons between the profile of needs for each group. This information on the needs to be met is essential as a basis for any forecasting.

DISTRIBUTION OF CASES ACCORDING TO AGE - It was important to highlight this basic demographic information. The table below reveals a progression in the average age according to group, a progression that was similar in each region.

Table 10: Distribution of Cases, According to Age

Age	Region and Clientele					
	Fredericton			Péninsule acadienne		
	New. cases	Re-assessments	Cohort	New cases	Re-assessments	Cohort
	%	%	%	%	%	%
Less than 65 years	3	2	0	0	0	0
65 to 69 years	15	10	2	24	2	9
70 to 74 years	13	22	20	16	12	2
75 to 79 years	18	16	10	14	28	23
80 to 84 years	27	22	23	27	26	30
85 to 89 years	18	20	22	14	16	25
90 to 94 years	2	26	17	4	6	9
95 to 102 years	3	0	7	0	2	4
Information missing	-	2	-	-	8	-
Group mean age	78,9 years	81,3 years	83,0 years	77,2 years	80,9 years	82,5 years
Standard deviation	7,8	8,3	7,9	7,8	6,7	6,6

IDENTIFIED NEEDS WITH RESPECT TO ACTIVITIES OF DAILY LIVING - Eating, dressing, grooming, foot care, bathing, toileting, and transfer are the activities considered essential to individual survival and well-being. In preparing the following table, consideration was given to the number of activities for which the individual needed regular or constant assistance (points 3 and 4 on the scale defined in Chapter II).

It can be seen that the needs identified are more or less the same for the new and reassessed cases in both regions. However, these needs are fewer in number than those identified for persons receiving enriched services, persons represented in the table by the current cohort. Indeed, in the Fredericton region, 41% of New Cases and 45% of Reassessed Cases needed regular or constant assistance with more than one activity of daily living, whereas 76% of persons in the current cohort had equivalent needs. In the Péninsule acadienne region, 40% of New Cases and 28% of Reassessed Cases needed regular or constant assistance with more than one activity of daily living, whereas 78% of persons in the region's current cohort had similar needs.

Table 11: Need of Assistance with Activities of Daily Living (ADL)

Number of activities for which regular or constant help is needed	Region and Clientele					
	Fredericton			Péninsule acadienne		
	New. cases	Re assessments	Present Cohort	New cases	Re assessments	Present Cohort
	%	%	%	%	%	%
None	32	28	8	52	60	10
One	27	27	16	8	12	12
Two	14	18	20	19	14	17
Three	7	10	16	6	6	32
Four	7	6	10	10	2	5
Five	3	3	4	0	0	7
Six	2	5	16	4	4	10
Seven	8	2	10	0	0	7

IDENTIFIED NEEDS TOWARDS INSTRUMENTAL ACTIVITIES OF DAILY LIVING - Shopping, using the telephone, banking, money management, meal preparation, housecleaning, and yard repairs are the seven activities which are instrumental to daily living. They are a set of activities that must normally be carried out on a daily basis for a household to operate smoothly. In preparing the following table, the number of activities with which an individual needed regular or constant assistance (points 3 and 4 on the scale defined in Chapter II) was considered.

An initial finding is that all of the groups studied needed more help with instrumental activities than they did with the activities of daily living. However, in both regions, the needs are not as great as those identified among the persons receiving enriched services, represented by the current cohort. In the Fredericton region, 88% of New Cases and Reassessed Cases needed regular or constant assistance with more than one activity of daily living as compared to 98% for persons in the current cohort. In the Péninsule acadienne region, 84% of the New Cases and 86% of the Reassessed Cases needed regular or constant assistance with more than one activity of daily living, as compared to 100% of the persons in this region's current cohort.

Table 12: Persons Needing Assistance with Instrumental Activities of Daily Living (IADL)

Number of activities for which regular or constant help is needed	Region and Clientele					
	Fredericton			Péninsule acadienne		
	New. cases	Re assessments	Present Cohort	New cases	Re assessments	Present Cohort
	%	%	%	%	%	%
None	7	8	0	8	4	0
One	5	4	2	8	10	0
Two	21	26	4	15	26	0
Three	10	10	4	10	18	2
Four	9	16	11	13	4	12
Five	12	20	6	17	10	32
Six	22	22	43	19	12	34
Seven	14	14	30	10	14	20

That concludes highlights of the information gathered from the forms completed during the multidisciplinary assessment. Comparative data on the level of needs of different clienteles was the main result of these studies.

SUMMARY AND CONCLUSION

The clientele studies reported in this chapter do not provide basis for conclusion on the proportion of cases admissible to enriched services among either new cases coming to the Single Entry Point door or among opened cases in the current Community Based Social Services caseload Nevertheless, these studies reveal that:

- In the Fredericton region, there were four main referral sources for new cases in order of importance: hospital or other institution, family, friends/neighbors, and social agency; in the Péninsule acadienne region, another social agency is the principal referral source, and a large number of persons came to the Single Entry Point on their own initiative;

- The average age of each group studied is very high (77 years and more) and there is an age progression from the new cases group (78,9 years in Fredericton and 77,2 years in the Péninsule acadienne region), to the reassessed cases group (81,3 years in Fredericton region and 80,9 years in the Péninsule acadienne region) to the cohorts representing the elderly receiving enriched services (83 years in Fredericton region and 82,5 years in the Péninsule acadienne region);

- The results of the multidisciplinary assessment point to fairly similar needs in the new cases and reassessed cases groups for both regions;

- The needs of these clienteles for regular or constant assistance with regard to instrumental activities of daily living and activities of daily living are very real, although less severe than for the current cohorts receiving enriched services.

With a view to client forecasting, this chapter presents some useful data. Surer knowledge of the clientele likely to be affected by the Single Entry Point model and enriched services could be obtained by forming a new cohort and studying their respective characteristics. The main advantage of the needs studies presented is that they make it possible to observe the difference in needs for the various clienteles studied. Moreover, in terms of the volume of cases to be handled, the conclusions presented are already supported over a period that, even though relatively short, is reliable for predicting major trends. Continuing these studies over a longer period would make it possible to confirm or disprove the trends observed.

CHAPTER VI

SERVICES OFFERED THROUGH THE SINGLE ENTRY POINT

One essential feature of the Single Entry Point model currently being studied in New Brunswick is the service options that can be offered to frail elderly who need them. There was general agreement in the opinion survey that the Single Entry Point model can be successful only where well-established services exist and if they are available to all. Of the approximate one hundred people who responded to a mail-out questionnaire, all mentioned the service options, generally indicating improvements were needed. On the other hand, the frail elderly who were surveyed reported great satisfaction with the services received. This matter will be dealt with in greater detail in Chapter X.

The following is a summary of the results of a study on service plans prepared for the frail elderly forming both present demonstration cohorts. As well, a brief account is given of the efforts undertaken in each pilot region to ensure that needed services were available throughout the region in a consistent manner and to expand the service options by developing new services that were determined necessary following the in-depth study of needs that require attention.

A. SERVICE PLANS FOR PERSONS IN THE PRESENT COHORTS

One of the steps in the multidisciplinary assessment is to prepare a service plan designed to encourage the frail elder's continuing autonomy and to meet the needs which have been identified. The service plan used is contained in Section 9C of the New Brunswick Assessment and Continuing Care Instrument.

An examination of the service plans on record for the elderly forming the present cohorts enabled us to observe how often each service of a pre-selected list of services was used for each of the cohorts. All listed service options appeared in the service plans reviewed; community services offered by volunteers were ranked along with purchased social support services and Extra-Mural Hospital services.

Over time, the services offered to the frail elder have to be adapted for their continually changing needs. For the study, a profile was produced indicating the services offered or provided at the time the cases were reassessed. It should be noted that Table 13 is a momentary representation of the service plans studied, plans that are bound to be adjusted frequently.

The table also show that the homemaker service is part of a large number of service plans. This service as well as in-home relief or respite care in institution, meal services and live-in housekeeper services are essential to enabling the frail elderly to continue living at home as they contribute to needs identified by the multidisciplinary assessment as instrumental activities in daily living (see Chapter III).

Nursing care services also appeared in a large number of service plans. Like physiotherapy, rehabilitation equipment, occupational therapy, respiratory therapy, dietary, and mental health care services, they helped to fill the health care needs of the frail elderly in the present demonstration cohorts.

Other needs identified were met by counselling and education/support services. For the Fredericton cohort, the service plans indicated only those cases needing counselling or education/support services offered by specialized staff. However, the service plans in the Péninsule acadienne reflected all needs for this type of service, including cases where the Single Entry Point professionals assumed responsibility for the counselling or education/support needs. It can be assumed that counselling and education/support services account in part for the comments made by close to one caregiver out of three to the effect that a feeling of security and peace of mind had resulted from the changes brought about by the Single Entry Point (Appendix C): having someone with whom one could share responsibilities and discuss problems.

Although other service options from the list appeared in fewer service plans, the help they gave to the persons who needed them was irreplaceable.

Table 13 - Momentary Representation of Service Usage, According to Service Plans

Services	Fredericton Cohort (N=50)	Péninsule acadienne Cohort (N=41)
	% of use	% of use
Homemaker	70	56
In-home relief	28	41
Live-in housekeeper	28	--
Home Health Service	52	49
Meal preparation	30	12
Respite care in institution	12	2
Rehabilitation equipment	8	22
Counselling *	4	88
Education-support	--	17
Friendly visiting	12	17
Handy person	12	5
Telephone reassurance	--	5
Heavy housework	20	5
Day care center	6	7
Transportation	8	10
Financial assistance	6	--
Life line	22	--
Medical assistance	2	7
Physiotherapy	10	10
Occupational therapy	12	**
Respiratory therapy	2	3
Dietetics	6	6
Mental health care	4	--
Self-help group	--	2
Pastoral	2	34

* Fredericton Cohort: requisitioned services only
Péninsule acadienne Cohort: requisitioned services and services given by the Single Entry Point professionals

** Service not available in the region

Geriatric assessment services do not appear in the table as the multidisciplinary assessments for the initial cohorts were already completed prior to the time period studied. It should be pointed out that, geriatric assessments were organized in both pilot regions despite the fact that a geriatric assessment and care unit does not exist in the Péninsule acadienne region.

The regional mental health clinics were also asked to conduct certain special assessments; this activity is not represented in the table above because these assessments had been completed for some time before the period under study.

B. SPECIAL STUDY OF TWO SERVICES

In order to provide a more in-depth knowledge of the needs that correspond to two frequently offered services, the homemaker service and the nursing care component of the home health services were the object of a special study.

THE HOMEMAKER SERVICE - The homemaker service is the one who appears most often in the service plans prepared for the frail elderly of both demonstration cohorts. The analysis of tasks was based on requisitions in 35 files chosen at random from the 58 persons receiving the service. Each region was represented: 17 cases from the Fredericton region and 18 cases from the Péninsule acadienne region.

From the task analysis, it was learned that in most cases the homemaker was asked to provide personal care (83%). Under personal care were grouped such duties as giving a bath, washing hair, help with grooming, transferring, toileting, dressing etc..

Also, the homemaker was frequently asked to do housework (63%), and sometimes to prepare meals (26%). On rare occasions (6%), other duties were assigned including relief, monitoring, help with walking, errands, transportation, and socializing.

The description of duties helped to pinpoint the requirements homemakers must meet. Being responsible for the personal care of a frail elder demands both thoughtfulness and tact, probably even more during the adjustment period of first receiving assistance.

THE NURSING CARE COMPONENT OF THE HOME HEALTH SERVICE - The analysis of tasks and functions of the nursing care component of the home health service was based on the Progress notes filled out by the nurses after each visit to an Extra-Mural Hospital patient. Each region was represented: 25 cases from the Fredericton region and 28 cases from the Péninsule acadienne region.

The first analysis of the many tasks performed by the nurses during their visits are related to a set of six major functions:

- Assessment	Initial assessment or re-assessment(s) due to change in condition or circumstances: family called or nurse noticed a major change. Also, planned reassessments i.e. planned according to the Single Entry Point process.
- Direct care	Any activity done by the nurse to or for the patient including: injection, chest auscultation, dressing, foot care, filling pill containers, taking vital signs (blood pressure, temperature, etc.). Specimen collection (urine, blood, etc.).
- Monitoring and supervision	On-going evaluation of a physical, mental or other condition or, family dynamics, physical environment, etc.
- Teaching	Instructions given to patient, family or homemaker, etc. including teaching a skill or giving information about the patient's condition.
- Support	Listening, giving emotional support, identifying problems as seen by patient or family.
- Communication	Can be verbal or written: contact with team members, notes reflecting consultation or discussion with other workers or agencies.

The second analysis, based on 20 cases followed by different nurses (10 in each region), showed that during the initial visit the assessment was usually combined with other functions. It also showed that direct care and monitoring were performed during each nursing care visit. Teaching was reported less frequently and appeared to be related to individual needs: ranging from 7 times for 10 visits to once for 15 visits. In total teaching was reported in 15 of the 20 cases studied. The function of communication also varied from case to case: ranging from 7 times for 14 visits to once for 15 visits. In total, team communications were reported in 15 of the 20 cases studied.

The function of support was reported in 5 of the 20 cases studied and happened once in each of these 5 cases.

This description of the tasks and functions performed by nurses during the visit gives a more complete picture of what nursing care component of the home health service implies.

C. SERVICE DEVELOPMENT

The Single Entry Point pilot project was intended to verify whether the service options defined by the Provincial Design Committee were sufficient to offer a real alternative to institutionalization. Part of the reason for choosing Fredericton and the Péninsule acadienne for the pilot was because of the service options already available there and their respective resources and infrastructures. The pilot project attempted to determine whether the infrastructures were strong enough and identify what, if any, additions and adjustments were necessary in order for these regions to achieve the objectives of the Single Entry Point system.

The information in this section is based on a study of the resource and service development plans in each pilot region and on a discussion of the subject at a meeting of the Linkage Committee, composed of the Provincial Coordinator and the Regional Coordinators of the Single Entry Point project. The purpose of the information is to illustrate how the development of resources and services was tackled in the pilot regions.

In each pilot region, a regional implementation committee was set up in order to establish an information network and also to form a working group that would focus on developing the resources and services needed to ensure the project's success. This committee held regular meetings and made a sustained effort to design and coordinate the necessary developments.

A number of meetings were also organized with formal service providers such as the Red Cross, Volunteer Bureau, People Care, Adult Day Center, etc. The purpose of these meetings was to discuss the objectives of the Single Entry Point project, study its effects on their organization, identify current needs, seek solutions, and anticipate future needs.

The Péninsule acadienne region concentrated first on establishing consistency in the availability of services throughout the region. Subsequently, an effort was made to establish the basic in-home relief service and to adapt the services to meet the volume of demand, which increased considerably with the implementation of the Single Entry Point. Since volunteer services such as support groups, telephone reassurance and friendly visiting were not widely known or used, work was done to give these services a higher profile.

It is planned that at the end of this first year of development, work will continue on expanding the accessibility of basic services such as meal services, homemaker service and support groups. It is planned also to make largely known the availability of emergency services after regular working hours. Projects include setting up self-help groups, participation in establishing a geriatric team and studying a peer counselling project for caregivers.

In Fredericton, since the basic services already existed effort concentrated on strengthening the infrastructure to meet the increased demand. In addition, a complete inventory was made of the resources available in the various parts of the region and a study completed on all the records of the frail elderly in the demonstration cohort, supplemented by interviews in order to clearly define the needs. A fourteen-point work plan was then prepared and implemented. The plan dealt with such matters as the gap between the demand for spaces in special care homes and their availability, the gap between the demand for friendly visiting and the availability of volunteers, the lack of emergency relief service on a 24-hour basis, and the need for a less costly alternative to hiring a live-in companion paid on an hourly basis. Systematic realization of this work plan has started during the pilot project period and is currently in progress.

This report on service development activities was intended to highlight the service options offered, as well as the importance of developing services adapted to the needs and making such services widely accessible. Now that this first year of development has been completed, both pilot regions are directing their efforts toward establishing therapeutic and educational services, especially for primary caregivers: meetings centered on the As Parents Grow Older theme, organizing self-help groups, establishing a peer counselling service, etc.

SUMMARY AND CONCLUSION

The frail elderly persons receiving enriched services need a great deal of support. The challenge of the pilot project was to offer these individuals services that would enable them to continue living in their own homes. In concluding this chapter, we indicate on the one hand, which services are most often necessary to accomplish that and, on the other hand, for which services does the study of gaps between the needs identified and the services currently available justify the development.

THE SERVICE PLANS - Each service option of the list is taken into account and plays a real role when the service plans are prepared, in both pilot regions.

- The services that appear most often in the Fredericton cohort's service plans are, in order of frequency: homemaker services (70%), home health services (52%), meal services (30%), in-home relief (28%), live-in housekeeper (28%), life line (22%), and heavy housework (20%).
- The services most often found on the Péninsule acadienne cohort's service plans are, in order of frequency: homemaker services (56%), home health services (49%), in-home relief (41%), rehabilitation equipment (22%), education/support (17%), and friendly visiting (17%).
- Specialized assessment services such as geriatric assessment and mental health assessment were used on a regular basis.

- Analysis of the homemaker service reveals that, in most cases (87%), the homemaker is asked to provide personal care. The homemaker is also often (63%) asked to do housework, and sometimes (26%) prepare meals. Infrequently (6%), other tasks are assigned: relief, monitoring, help with walking, errands, transportation, and socializing.
- Analysis of the nursing care component of home health services indicates that the main tasks performed during visits are assessment, direct care, and control or monitoring. Tasks related to teaching and moral support were also mentioned a few times.

SERVICES TO BE DEVELOPED - In order to offer a real alternative to placement in an institution, a large number of service options are necessary. Moreover, these services have to be sufficiently well established and flexible to absorb to the large augmentation of the demand for services at the onset of the Single Entry Point model. On the basis of a study of how services evolved in each pilot regions, it can be concluded that:

- A large number of services have to be set up at the very beginning of the project, if they do not already exist,
- The services must be available in all parts of the region;
- This service infrastructure must be solid enough to meet an increase in the demand;
- According to the results of an analysis of the needs of the frail elderly and their caregivers, development of the following services must be given priority:
    - support group
    - geriatric team
    - friendly visiting
    - volunteer network
    - emergency relief - 24 hours
    - number of spaces in special care homes
    - peer counselling (for informal caregivers)
    - alternative to service of companion hired on hourly basis;

Although the approaches used to develop resources and services in the two pilot regions are not very costly, they do require a very large amount of work on the part of the professionals and administrators associated with the community services involved in this development. These approaches generate community awareness as they rely on the community's capacity for change and, on the mutual help that people facing similar situations can provide.

CHAPTER VII

COSTS RELATED TO THE SINGLE ENTRY POINT MODEL

The aim of this chapter is to present the results of an analysis of the costs related to the Single Entry Point model. The average monthly costs for the Single Entry Point pilot project was calculated for both the purchased social support services and the Extra-Mural Hospital health services which were part of the 'enriched services' given to the frail elders in both demonstration cohorts. This chapter also presents a study of the financial participation of the same elderly.

Another study of costs led to the compilation of a per diem rate, taking into account six factors: the costs of purchased social support services, the costs of the Extra-Mural Hospital health services, the costs for additional staff for Family and Community Social Services, the service development costs, the panel costs and the staff training costs.

Finally, results of a time study are also presented in this chapter.

A. COSTS OF PURCHASED SOCIAL SUPPORT SERVICES

Two sets of information are presented in this first domain of costs. The first is based on an analysis of findings in the Progress report (August 1990) and states the costs for purchased social support services for persons forming the initial demonstration cohorts: 60 frail elderly in the Fredericton cohort and 57 in the Péninsule acadienne cohort. The second concerns the present cohorts: 50 frail elderly in the Fredericton cohort and 41 in the Péninsule acadienne cohort who were still in the demonstration cohorts on the closing date of the evaluation, September 30, 1990. This second set of information will allow comparisons to be made of the costs per person, over a certain period of time.

COSTS FOR PURCHASED SOCIAL SUPPORT SERVICES FOR THE INITIAL DEMONSTRATION COHORTS - Table 14 presents the minimum, maximum, and average monthly costs to the department for social support services for each initial demonstration cohorts.

Table 14 - Departmental Monthly Costs for Purchased Social Support Services (initial cohorts)

Initial Cohorts	Number of persons	Monthly Costs Minimum $	Maximum $	Average $
Fredericton	60	0	1470	587
Péninsule	57	0	717	294

Due to differences in the application of the eligibility criteria for enriched services, no direct comparison of monthly costs for social support services can be made between cohorts (see Chapter II, Section A). From Table 14 it can be calculated that at the particular point in time, the total monthly costs for social support services for the Fredericton cohort was $35 220 and that it was $16 758 for the Péninsule acadienne cohort.

Table 15 shows the distribution of monthly Departmental costs for purchased community support services at a particular point in time during the period ending March 31, 1990. This distribution is presented for descriptive purposes. Any hypothesis linking it to factors such as the strength of the natural support network, the relationship with the primary caregiver, the costs of services in each pilot region, the financial participation of the clients and their families, etc. remains to be verified. It is reasonable to think however that the modality of applying the eligibility criteria for enriched services which was used in the Fredericton region had an effect on the number of cases with service plans costing less than $400 and consequently also had an effect on the distribution of costs given below.

Table 15 - Distribution of Monthly Departmental Costs for Purchased Community Support Services (initial cohorts), Period Ending March 31, 1990

Category of costs	Fredericton Cohort (N=60)	Péninsule acadienne Cohort (N=57)
$	% of cases	% of cases
0	7	14
1-99	8	7
100-399	32	47
400-699	13	30
700-999	18	2
1 000 et +	22	0

COSTS FOR PURCHASED SOCIAL SUPPORT SERVICES FOR THE PRESENT DEMONSTRATION COHORTS - Table 16 presents the minimum, maximum, and average monthly costs for the Department for purchased social support services for the present demonstration cohorts. In comparing the situation for the two occasions chosen for evaluation, it can be concluded that the average monthly costs per client increased over an average stay of 9 months in the Fredericton cohort and 8 months in the Péninsule acadienne cohort (see Chapter II, Table 3).

Table 16 - Departmental Monthly Costs for Purchased Social Support Services (present cohorts)

Present Cohorts	Number of persons	Monthly Costs Minimum $	Maximum $	Average $
Fredericton	50			
March 31, 1990		0	1470	601
Sept. 30, 1990		0	1470	646
Péninsule acadienne	41			
March 31, 1990		0	717	294
Sept. 30, 1990		0	1214	412

It must be noted that the information available here is only representative of the service plans at a particular point in time. Continuous data is needed over a two or three year period in order to establish a sound financial information base with sufficient reliability for projecting costs.

B. COSTS OF THE HEALTH SERVICES PROVIDED BY THE EXTRA-MURAL HOSPITAL

Monthly Extra-Mural Hospital service costs for the initial cohorts have been established using information received from the Extra-Mural Hospital* for the months of April, May and June 1990. Based on their 1989-90 year end reports, the costs per visit was $60; this cost includes certain overhead costs, e.g. use of rehabilitation equipment, and drug costs. A second set of information was obtained in the same manner; for the period of July, August and September 1990. This permits a six month comparison of the health services provided by Extra-Mural to frail elders in the present cohorts.

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* Letter received (July 26, 1990) from Thomas Maston, C.A., Assistant Executive Director, Financial Services. Extra-Mural Hospital.

COSTS FOR HEALTH SERVICES FOR THE INITIAL DEMONSTRATION COHORTS - A study was also made of health service costs. Table 17 presents the minimum, maximum, and average monthly costs of Extra-Mural Hospital services for the initial demonstration cohorts.

Table 17 - Monthly Extra-Mural Hospital Service Costs for the Initial Cohorts

Initial Cohorts	Number of persons	Monthly Costs Minimum $	Maximum $	Average $
Fredericton	60	0	1840	130
Péninsule acadienne	57	0	1360	225

Again, due to differences in the application of the eligibility criteria for enriched services, no direct comparison of monthly Extra-Mural Hospital service costs can be made between cohorts (see Chapter II, Section A) From Table 17 it can be calculated that at that particular point in time, the total monthly costs for Extra-Mural Hospital services for the Fredericton cohort was $7 800 and $12 825 for the Péninsule acadienne cohort.

Table 18 below shows the distribution of monthly Extra-Mural Hospital costs for services offered to enriched services clients of the initial demonstration cohorts for the period ending on March 31, 1990.

Table 18 - Distribution of Monthly Extra-Mural Hospital Costs (initial cohorts), Period Ending March 30, 1990

Category of costs	Fredericton Cohort (N=60)	Péninsule acadienne Cohort (N=57)
$	% of cases	% of cases
0	42	28
20-80	22	26
100-380	28	21
400-880	5	20
900 et +	3	5

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[*] The costs being of $60 per visit, the categories of costs are multiple of 20. One visit over a 3 month period results in a monthly costs of $20.

COSTS OF HEALTH SERVICES FOR THE PRESENT DEMONSTRATION COHORTS - Table 19 presents the minimum, maximum, and average monthly costs of Extra-Mural Hospital services for the present demonstration cohorts. Comparing the situation on the two occasions chosen for evaluation purposes, it can be seen that in both cohorts the average monthly costs per client has decreased over the six month period.

Table 19 - Monthly Extra-Mural Hospital Service Costs for the Present Cohorts

Present Cohorts	Number of persons	Monthly Costs Minimum $	Monthly Costs Maximum $	Monthly Costs Average $
Fredericton	50			
June 30, 1990		0	1 840	150
Sept. 30, 1990		0	440	77
Péninsule	41			
June 30, 1990		0	1 160	196
Sept. 30, 1990		0	680	122

It must be noted that this information consists of continuous data for a six month period and thus could be part of a set of data that could be used with reliability for projection purposes.

C. FINANCIAL PARTICIPATION OF THE CLIENTELE

In order to describe the extent of financial participation by frail elderly in the demonstration cohorts, two sets of data were gathered corresponding to two angles from which to consider participation. First, the effective financial participation of the individual was considered and then the household income was considered.

It must be noted that for health services, some clients participated by buying equipment, supplies and drugs themselves while others paid the deductible amount on their drug insurance plan. For the present evaluation financial participation for health services has not been quantified.

EFFECTIVE FINANCIAL PARTICIPATION BY FRAIL ELDERLY IN THE INITIAL COHORTS - From the information collected, the following distribution was established for the monthly financial participation toward social support services. Some regional differences can be observed in this area. It should be noted that financial participation is not only in proportion to income but that it is also relative to the costs of purchased social services in the service plan.

Table 20 - Distribution of Client's Monthly Participation Toward Social Support Services Costs (Initial Cohorts), Period Ending March 31, 1990

Category of costs	Fredericton Cohort (N=60)	Péninsule acadienne Cohort (N=57)
$	% of cases	% of cases
0	37	74
1-99	28	14
100-399	17	0
400-699	8	10
700-999	7	2
1000 et +	3	0

HOUSEHOLD INCOME OF FRAIL ELDERLY IN THE PRESENT DEMONSTRATION COHORTS - Based on information presented in Appendix G, Table 21 shows the distribution of annual household income of frail elderly in the demonstration cohorts on September 30, 1990.

Table 21 - Annual Household Income of the Elderly of the Present Cohorts

Category of income	Fredericton Cohort (N=60)	Péninsule acadienne Cohort (N=57)
$	% of cases	% of cases
Less than 10 000	30	61
10 000 to 14 999	34	30
15 000 to 19 999	18	7
20 000 or more	16	2
Non divulged	2	0

* Household meaning client only if single or widowed and client and spouse, if married

D. PER DIEM FOR ENRICHED SERVICES

A per diem rate was established taking into account six factors: the costs of purchased social support services, the costs of the Extra-Mural Hospital health services, additional staffing costs for Family and Community Social Services, service development costs, panel costs and staff training costs.

THE COSTS OF PURCHASED SOCIAL SUPPORT SERVICES - As with service plans which vary from time to time to correspond with changing needs so do the costs of purchased social support services such as homemaker, meal service etc. In order to calculate a per diem, the costs of purchased social support services for both the initial cohorts (March 31, 1990) and the present cohorts (September 30, 1990) were used.

As mentioned in Section A, with respect to the initial cohorts, the Departmental costs for social support services to the 60 frail elderly of the Fredericton cohort was $35 220 a month and $16 758 a month for the 57 of the Péninsule acadienne cohort. For the present cohorts, the costs of social support services was $32 307 a month for the Fredericton cohort (50 elderly) and $16 758 a month for the Péninsule acadienne cohort (41 elderly).

THE COSTS OF EXTRA-MURAL HOSPITAL HOME HEALTH SERVICES - Nursing care, physiotherapy and respiratory therapy are some of the services provided to the frail elderly through the Single Entry Point model. The costs of these services are available for a period of three months. For the frail elderly forming the initial demonstration cohorts costs, are available for a three month period and for the present cohorts, costs are available for a six month period. Information from both periods were used in calculating the per diem.

As mentioned in Section B, with respect to the initial cohorts, Extra-Mural Hospital costs for health services to the 60 frail elderly of the Fredericton cohort was $7800 a month and $12 440 a month for the 57 elderly of the Péninsule acadienne cohort. The costs for health services were $3860 a month for the Fredericton present cohort (50 elderly) and $5020 a month for the Péninsule acadienne present cohort (41 elderly).

It must be noted that during the pilot project period, the Extra-Mural Hospital did not add any staff to its personnel because of the temporary character of the project. However, additional staff will be needed when the Single Entry Point becomes a program.

COSTS FOR ADDITIONAL STAFF FOR FCSS - Additional Family and Community Social Services staff resources were required to implement major functions of the Single Entry Point model: assessment of new cases coming to the door, case managing the enriched services clientele, providing professional counselling to clients, caregivers and families, maintaining an updated and efficient nursing home waiting list, establishing liaison with stakeholders and coordinating project activities. In total, seven person-years had to be added to assume these tasks: regional coordinator, case aid, and five social workers.

During the project ,the annualized incremental staffing costs for the two regions were $185 094 in the Fredericton region and $147 172 in the Péninsule acadienne region.

SERVICE DEVELOPMENT COSTS - As seen in Section D of Chapter VI, service development was an ongoing activity throughout the pilot project. The Fredericton region focused on identifying the service needs of each enriched services client; linking with established service agencies to discuss needs and explore the possibility of service development; and, facilitating development at minimal costs. In order to accomplish these tasks, a resource development officer was hired for a period of six months at a costs of $23 305. The services developed during the project include a strengthening program, an educational program for caregivers, a senior's fair and an adult day center. These were developed at a costs of $4 800. One service, namely the caregiver training program was developed in partnership with the St. Thomas University Third Age Center which also shared some of the development costs.

In the Péninsule acadienne region there was a need to develop basic services. An in-home relief service was implemented to support natural caregivers. A geriatric consultation capacity was developed in collaboration with the Tracadie Hospital. As well, the educational program "As Parents Grow Older" was provided to family members of frail elderly clients. These services were implemented at a total costs of $41 000.

PANEL COSTS - The Single Entry Point panel met regularly on a weekly basis. The annual operating costs of the panel was approximately $15 000 per region.

STAFF TRAINING COSTS - An initial provincial training session was held and on-going training activities were organized in both pilot regions for the multidisciplinary teams focussing on the development of assessment skills, team building, understanding the aging process, etc. The total costs of training initiatives was $2 500 in the Fredericton region, $4 500 in the Péninsule acadienne and $4 500 also for the provincial training program.

The per diem rate - The following table summarizes the analysis done in this section and presents the total per diem that has been compiled for the frail elderly for both initial and present cohorts.

Table 22 - Summary of Costs and Per Diem

Contributing factor	Fredericton (Nb=60)	Péninsule acadienne (Nb=57)
Summary of costs		
FCSS staff*	185 094	147 172
Service development	28 105	41 000
Panel	15 000	15 000
Training**	4 750	6 750
Total	232 949	209 922
Per diem		
Preceding four factors	10.64	10.09
Social support	20.27	11.61
Extra-Mural Hospital	3.40	5.60
Total	34.31	27.30

* Family and Community Social Services.

** The amount of $4 500 for the training program was divided equally between regions.

E. COSTS IN TIME

A two-part time study was done to determine the amount of time spent on the main functions performed in the Single Entry Point model. The data was gathered over a six week period starting with the first week of November 1990. General functions of social work such as resource development and outreach, staff development and education were monitored together with client related functions and activities during the course of the Single Entry Point process: assessment, service planning, panel attendance, service plan implementation, direct service delivery and service plan monitoring.

ACTIVITIES RELATED TO GENERAL FUNCTIONS OF SOCIAL WORK - For six weeks seven social workers kept a record of the time they spent on the three general functions. Activities related to these functions were as follows:

Development and outreach - meetings with community groups, boards, agencies, etc., for the purpose of identifying service needs, assisting in developing services, assisting service providers and providing information about the project and the services available.

Staff development - attendance at training sessions, staff meetings, consultation with supervisor or other professionals, supervision.

Education - development and delivery of educational materials or sessions.

A compilation of the results of this study shows that activities related to resource development and outreach, staff development and education accounted for nearly a 1 day per week per worker during the six week study period.

FUNCTIONS AND ACTIVITIES RELATED TO CLIENT INTERVENTION - The functions and activities related to client intervention were monitored, via a specially designed form, for 9 cases in the Fredericton region and 6 cases in the Péninsule acadienne region, for a six week period. Among these cases, some were social assessment case only or health assessment case only, others were assessed for enriched services and others for placement on the nursing home waiting list. One case refused the assessment and was therefore discarded for the study. Each time one of these cases received attention whether for assessment, preparation of service plan or other Single Entry Point related functions, the person performing the task noted on the form what activity was performed and the related function, the amount of time spent, his or her name and title, and the date on which the activity took place.

The following types of activities were monitored: direct contact, telephone, travel, office work, consultation, case conference and computer work.

A compilation of the results of this study shows that the time spent on activities and functions related to the Single Entry Point process vary greatly from case to case due to the type of assessment done, the travel time necessary to meet the applicant, the complexity of the service plan to be prepared, etc.. The following tables summarize the information gathered in relation to the assessment and the service plan preparation functions, the only two functions a 6 week study period enabled observations to be made about most of the cases studied.

Table 23 - Time Study for the Assessment Function of the Single Entry Point Model

Types of Assessment	Number of cases	Time Spent			
		Minimum (minutes)	Maximum (minutes)	Average (minutes)	Median (minutes)
All types	14	127	628	319	215
One phase only	5	127	212	169	170
Complete assessment	9	182	628	402	405
Phase I	9	100	530	282	265
Phase II	9	35	245	112	110
Direct contact for evaluation purposes	14	62	290	124	115

Assessment comprises many activities. The direct contact with the elderly being assessed is an essential part of this function. On the 14 cases for which we have information, the time spent in direct contact for assessment purposes varied between one to five hours, with an average of two hours per case. The assessment also includes telephone contacts, travels, office and computer work along with consultation activities.

There can be only one phase to the assessment, this phase being either the social assessment or the health assessment. The five cases of this type in the present study requested an average of 2,8 hours of work.

Among the cases followed in the study, full assessment was completed for nine. The time spent varied between three to ten hours, with a mean of 6.7 hours. The assessment which took ten hours was completed for a person needing enriched services and required some specialized assessments, along with consultations. Moreover, the elderly person being assessed insisted on knowing all the results of the assessments which took additional time from the professionals doing the assessment. This case is representative of approximately 5% of the cases assessed in the Single Entry Point process.

To prepare a service plan, a number of activities are completed: telephone contacts, research, consultation, case conference, office and computer work, etc. In the 12 cases for which a service plan was prepared during the 6 week study period, this function required between 15 minutes to 9.4 hours, with an average time of 2.4 hours. It can be assumed that, in situations where an elderly is presenting with many needs, considerable time will have to be spent by the professional on research for the appropriate services, at acceptable costs.

Table 24 - Time Study for Service Plan Preparation within the Single Entry Point Model

Types of Service Plan	Number of cases	Time Spent Minimum (minutes)	Maximum (minutes)	Average (minutes)	Median (minutes)
After one phase	3	15	70	36	2555
After complete assessment	9	32	565	170	130
All cases	12	15	565	145	115

The results of this study are given for descriptive purposes. In order to establish standards, the same time study would have to be done for a longer period of time and in various settings, particularly in regions that are not currently applying the Single Entry Point model.

SUMMARY AND CONCLUSION

In conclusion, the data related to costs presented in this chapter indicate that:

- the costs paid by the Department for social support services span a very broad spectrum, ranging from 0 to $1470, the maximum allowed by the project;

- at the time of collecting the first set of data, in 53% of the service plans for the Fredericton cohort, the social support services cost between $1 and $699 per month; in the Péninsule acadienne, 84% of the service plans cost between $1 and $699 per month for purchased social support services;

- costs for purchased social support services for the present cohorts were higher in September 1991 than in March 1990;

- the policy concerning financial participation was applied in all the cases: 63% of the frail elderly in the Fredericton cohort and 26% of the Péninsule acadienne cohort contributed financially toward the cost of the services they received.

The health service costs were studied over a period of six consecutive months. It was found that:

- these costs span a very broad spectrum, ranging from 0 to $1840;

- at the time of collecting the first set of data, in 55% of plans for the Fredericton, the health services costs ranged between $20 and $880 per month; in the Péninsule acadienne, 67% of the cohort's service plans cost between $20 and $880;

- for the present cohorts, the costs of the health services proved to be lower during the past three months than those for the first three months.

Finally, information was gathered in order to calculate a per diem for the enriched service plans. In making this calculation, the following factors were taken into account:

- purchased social support services;
- health services;
- additional staffing for FCSS;
- service development;
- the panel;
- staff training.

For the pilot period of the project, the per diems have been established at $34.31 for the Fredericton cohort and $27.30 for the Péninsule acadienne cohort.

The **time study** conducted over a six-week period at the end of the pilot project had two parts: one part looked at the activities of social workers related to their general functions, and the other, the activities of principal members of the multidisciplinary team in relation to the functions directly associated with the clients.

-The results indicate that, during the period studied, social workers spent nearly one day per week on activities related to general functions such as resource development, various contacts with community groups or agencies(liaison, information, education), and professional development.

- The time social workers and health workers spent on functions directly associated with the clients can be broken down as follows:
  - 3 to 10 hours (7 hours on average) for all activities related to a complete multidisciplinary assessment (direct contacts, specialized assessments, telephone calls, travel, consultation, case conference, office work, work on computer, etc.);
  - 1.6 to 9 hours for activities related to the first phase of the multidisciplinary assessment (4 hours on average - same activities as above);
  - 1 to 6.3 hours for direct contacts with a client and his/her caregiver for the purpose of multidisciplinary assessment (3 hours on average);
  - 35 minutes to 9.4 hours for activities related to preparation of service plan following a complete multidisciplinary assessment (3 hours on average - telephone calls, research, consultation, case conference, work on computer, etc.).

The cost analysis reported in this chapter was based on a total of 117 cases over a period ranging from 6 to 12 months. The purpose of the cost analysis was to help verify the applicability of the Single Entry Point model. The time study had the same aim; it involved 15 cases over a six-week period. The data provides a better understanding of the contribution the multidisciplinary team makes to the Single Entry Point approach and procedures.

CHAPTER VIII

EFFECTS OF THE SINGLE ENTRY POINT MODEL ON TWO COMPONENTS OF THE LONG TERM CARE SYSTEM

Application of the Single Entry Point model has had immediate effects on two components of the long term care system in both pilot regions. The aim of this chapter is to report the effects first on the volume of cases handled by the Community Based Services for Seniors and second on the nursing home waiting list. This chapter also indicates the effects the enriched services had on the profile of needs of the elderly that are now registered on the nursing home waiting list.

A. EFFECTS OF THE SINGLE ENTRY POINT MODEL ON THE VOLUME OF CASES HANDLED BY CBSS

This section gives a description of the effects of the Single Entry Point model first on the monthly volume of cases handled by the Community Based Services for Seniors and then on intake and case registration activities.

MONTHLY VOLUME - According to reports produced by the RPSS information system, the monthly volume of cases handled by Community Based Services for Seniors (monthly caseload) increased in both pilot regions. The comparison was based over two years: from January to December 1989 and from January to December 1990. Although the monthly volume of cases for the same period increased 6.3% in the province's other ten regions; in the Fredericton region and in the Péninsule acadienne it increased 14.2% and 14.9% respectively.

Although the Single Entry Point pilot project was launched at the beginning of November 1989, the effect on case registration did not materialize until after the multidisciplinary assessment were completed on the first cases. We therefore think it justified to compare the situation beginning in January.

Several factors may have contributed to the greater increase found in the two regions of Fredericton and the Péninsule acadienne, including:

- At the start of the pilot project, several persons whose names were on the nursing home waiting list were registered for enriched services - equivalent to 6 cases/year for the Fredericton region and to 4.5 cases/year for the Péninsule acadienne region.

- Persons who previously went directly to nursing homes to place their names on the waiting list were now referred to the Single Entry Point - according to the nursing home waiting list statistics from November 1988 to October 1989, a monthly average of 17.5 cases in the Fredericton region and 8 cases in the Péninsule acadienne region were assessed with a view to placement on the nursing home waiting list.

- Persons registered for regular services who previously would have been added to the nursing home waiting list as their needs could not be met through these services, now form part of the cases receiving enriched services.

- Cases receiving extended care were referred to the Single Entry Point program by Public Health for the purpose of additional assessment and services.

- Publicity surrounding the pilot project and the interest of a number of stakeholders involved in this project created a ripple effect.

It is difficult to determine the exact role played by this set of factors in increasing the monthly volume of cases handled. However, table 25 presents the available information for three of the factors discussed above, letting us judge more precisely of their importance.

Table 25. Relative Importance of Three Factors
on Growth of Volume of Cases Handled for a One Year Period

Factors	Number of cases handled per region	
	Fredericton	Péninsule acadienne
On nursing home waiting list at the onset of the project	6	6
Requests for admission to a nursing home	210	96
Long-term care cases transferred to Extra-Mural Hospital	63	21
Total	279	123

VOLUME OF INTAKE AND CASE REGISTRATION ACTIVITY - The Single Entry Point pilot project had an immediate impact on intake activity after it was launched in early November 1989. A study was conducted of the major activities taking place during intake and case registration over two seven-month periods: April to October 1989 and April to October 1990.

The following table shows that the Single Entry Point project had a significant impact on the number of elderly persons requesting services. In fact, in both regions, the number of persons received at Intake increased by 92%. On the other hand, the percentage of persons for whom a file was opened after the assessment, was lower than before. Whereas, in 1989, files were opened for 73% of intakes in the Fredericton region and 60% of intakes in the Péninsule acadienne region, the figure fell to only 56% during a comparable period in 1990. This suggests that the screening done at Intake and the selection inherent in the multidisciplinary assessment procedure play an effective role.

Table 26. Volume of Cases Handled at Intake and at Registration

Region	Cases received at intake	Cases referred for assessment		Cases opened	
	Average	Average	% of intake	Average	% of intake
Fredericton					
. April to Oct. 1989	37	27	73	27	73
. April to Oct. 1990	71	48	68	40	56
. % of change in 1990	92%				-17%
Péninsule acadienne					
. April to Oct. 1989	25	15	60	15	60
. April to Oct. 1990	48	30	63	27	56
. % of change in 1990	92%				-04%

This study shows two trends: growth in the volume of cases handled by the Community Based Services for Seniors was greater in the two pilot regions than growth in other regions of the province; a reduction in the proportion of cases opened compared to cases received at intake in the two pilot regions.

B. EFFECTS OF THE SINGLE ENTRY POINT ON THE NURSING HOME WAITING LIST

This section gives a description of the effects of the Single Entry Point model on the nursing home waiting list in relation to the number of names on the list, the average waiting period before admission to a nursing home and the origin of the elderly person admitted to the nursing home during the pilot project period for both regions.

REDUCTION IN NUMBER OF NAMES ON THE LIST - The reduced number of names on the nursing home waiting list is an effect of Single Entry Point that can be observed from month to month in both pilot regions. From the information in the following table, it can be seen that this effect is stable. Over the same nine month period, taking into account all nursing homes in both regions, the average monthly total in the pool for the Fredericton region was reduced from 89.0 in 1989 to 14.5 in 1990 and from 60.1 in 1989 to 14.4 in 1990 in the Péninsule acadienne region.

Table 27. Number of Frail Elderly Registered on the Waiting List (April 1 to September 30, 1989 and 1990).

		Jan.	Feb.	March	April	May	June	July	Aug.t	Sept.	Avg
FREDERICTON											
Admitted to pool	1989	13	19	20	12	19	17	23	24	13	17.8
	1990	21	19	9	12	8	14	15	8	11	13.0
Admitted to nursing home	1989	15	15	18	18	11	11	9	9	11	13.0
	1990	17	15	12	16	8	9	10	8	7	11.3
Removed from pool	1989	4	2	8	13	4	6	4	11	2	6.0
	1990	5	2	2	2	0	2	1	0	6	2.2
Total in pool: month start	1989	103	97	99	93	74	78	78	88	92	89.1
	1990	16	15	19	16	10	10	13	17	17	14.8
Total in pool month end	1989	97	99	93	74	78	78	88	92	92	87.9
	1990	15	17	16	10	10	13	17	17	15	14.4
PÉN. ACAD.											
Admitted to pool	1989	6	5	5	10	7	6	6	2	8	6.1
	1990	9	9	9	2	6	4	4	9	7	6.6
Admitted to nursing home	1989	5	3	4	6	1	3	2	5	3	3.6
	1990	2	4	6	10	4	6	7	8	5	5.8
Removed from pool	1989	1	0	2	1	0	1	6	1	2	1.6
	1990	1	2	2	0	2	0	0	1	0	0.9
Total in pool: month start	1989	65	65	67	52	55	61	63	61	57	60.7
	1990	12	18	21	22	14	14	12	9	9	14.6
Total in pool month end	1989	65	67	52	55	61	63	61	92	92	67.6
	1990	18	21	22	14	14	12	9	17	15	15.8

REDUCTION IN THE AVERAGE NUMBER OF DAYS BEFORE ADMISSION - Using information gathered through the Single Entry Point project, the average waiting period was studied for persons who were recommended by the panel for admission to a nursing home.

The results of the study showed that during the six month period beginning April 1 and ending September 30, the 46 clients in the Fredericton region who were placed on the nursing home waiting list and later admitted to a nursing home, waited an average of 18.6 days.

In the Péninsule acadienne region, during the same six month period, the 29 clients who were placed on the nursing home waiting list and later admitted to a nursing home, waited an average of 16.5 days.

A reduced waiting period for admission to a nursing home is another effect of Single Entry Point. In order to provide a basis for judgment, an attempt was made to assemble comparative data. However, these efforts did not have the expected outcome partly because it is difficult to describe such a complex phenomenon with a few statistics. The reduced waiting period was important enough to foster comment, as expressed during the opinion survey, to the effect that a shorter waiting period was evident and that it meant less time to adapt to the idea and reality of the coming separation.

STUDY OF THE ADMISSIONS IN NURSING HOMES - A study of admissions during the course of the pilot project was done with the participation of each nursing home in the Fredericton region and Péninsule acadienne region. The form used for this study looked at:

a) number of new cases admitted from the Single Entry Point region;
b) number of transfers from within the region;
c) number of new cases admitted from other regions in the province;
d) number of transfers from other regions in the province;
e) number of admissions from outside of province;
f) total number of beds in the nursing home.

This information was gathered for an eleven month period beginning December 1989 and ending October 1990. An analysis of the data shows that, in the Fredericton region, 46,.% of all persons admitted to a nursing home came from Single Entry Point referrals. In the Péninsule acadienne region, 46.5% of all persons admitted to a nursing home were also Single Entry Point referrals. In that region, another 26.7% of the admissions could not be traced as direct Single Entry Point referrals at the time of the compilation of data.

Transfers from other nursing homes in the region accounted for 26.8% of the admissions in the Fredericton region and for 16.3% of the admissions in the Péninsule acadienne region. Of these transfers, some could have been prior Single Entry Point referrals.

On the other hand, in the Fredericton region, persons admitted from other regions of the province accounted for 25.4% of admissions during the period studied. In the Péninsule acadienne region, persons admitted from other regions of the province account for 10.5% of admissions in the same period.

In both pilot regions, the nursing home clientele is gradually being replaced by one who has been going through a different set of selection criteria and procedures. It is difficult however to determine the rate at which such a change is happening because a number of factors may influence the rate. From the information gathered, it can see that at one point in time, 16.1% of the clients of the nursing homes in the Fredericton region and 11.8% in the Péninsule acadienne region were referred through Single Entry Point.

In conclusion, we can affirm that the Single Entry Point has had effects on the nursing home waiting list. The list has been reduced by 84% in the Fredericton region and by 76% in the Péninsule acadienne region. This reduction, which has been of equivalent proportion. over the 9 month period studied could have resulted in a certain number of vacant beds if, during the pilot project period, persons from outside the pilot regions had not been admitted to the nursing home of these regions. We must note also that the waiting period before admission to a nursing home has been reduced to less than 20 days in each of the pilot regions.

C. PROFILE OF NEEDS OF THE ELDERLY NOW REGISTERED ON THE WAITING LIST

In order to describe the needs of frail elders placed on the nursing home waiting list following the Single Entry Point process, data from sections 1B, 2A, 4E and 7 of the New Brunswick Assessment for Continuing Care Instrument has been gathered for 30 cases in each pilot region. A compilation of this data appears in the last column of Appendix H. The profile of needs for this group can be compared with the profile for persons who are kept in the community while receiving enriched services.

Insights can also be gained by comparing the profile of needs for frail elders placed on the nursing home waiting list through Single Entry Point with the profile of needs for persons who appeared on the nursing home waiting list at the beginning of the project. The 90% reduction in the Fredericton nursing home waiting list on November 1, 1989, and the 84% reduction in the Péninsule acadienne region nursing home waiting list can be accounted for by a number of factors other than services through Single Entry Point: registration to other programs; personal decision to withdraw from the list; moving to another region; death; admission to hospital or a palliative care unit; and, admission to nursing home. However, it can be assumed that the 26 persons from the Fredericton region and the 14 from the Péninsule acadienne region (see Table 1 of Chapter II) who were determined eligible for a nursing home through the previous assessment process represent a good proportion of the persons who would have been admitted to a nursing home, if the Single Entry Point pilot had not been implemented.

The profile includes comparative information on specific elements of each domain of need (as identified in Chapter II) presenting the most severe problems for many frail elderly in the demonstration cohort. For this comparison, we considered the proportion of each group having severe or very severe problems (points 3 and 4 on the scale presented in Chapter II).

Basic information from the comparison appears in the following table. The first three columns of the table relate to three groups from the Fredericton region, and the three last columns, to three groups from the Péninsule acadienne region. The "Cohort" column shows the status of the demonstration cohort as of September 30: "Group A" column shows the status, as of November 1989, for the elderly whose names were on the Nursing home waiting list at the onset of the Single Entry Point pilot project; "Group B" column shows the status of a group of frail elderly whose names were placed on the Nursing home waiting list through Single Entry Point.

The table also shows that the frail elderly who were placed on the Nursing home waiting list after the pilot project began are more frail than those of the other two groups, in practically every area under study. This deterioration of health status appears more evident in the mental health and psychosocial areas where severe or very severe problems were reported for more than 40% of those in the Fredericton region and 50% or more in the Péninsule acadienne region. This appears to be one of the impacts of implementing the Single Entry Point process.

Table 28 Proportion of Frail Elderly Having Severe or Very Severe Problems, According to Group and by Region.

Domain of needs	Fredericton			Péninsule acadienne		
	Cohort	Nursing Home Waiting List		Cohort	Nursing Home Waiting List	
		Group A	Group B		Group A	Group B
	(Nb=50) %	(Nb=26) %	(Nb=30) %	(Nb=41) %	(Nb=14) %	(Nb=30) %
Physical Health Status						
Management of Medications	52	16	77	66	54	77
Physical Functions	49	23	64	51	29	73
Urinary Management	35	19	41	17	29	47
Bowel Management	28	8	48	15	14	47
Tissue/Skin Management	28	12	45	7	7	37
Pain Management	17	4	31	5	0	23
Mobility						
Indoor Mobility	29	12	50	27	8	41
Outdoor Mobility	60	27	71	61	31	69
Stairs/Ramps	65	32	68	85	71	80
Transportation	74	46	79	78	31	72
Activities of Daily Living						
Eating	15	12	36	13	15	24
Dressing	38	19	71	37	23	69
Grooming	53	27	71	46	23	72
Bathing	81	46	93	83	77	96
Toileting	38	24	63	27	15	45
Transferring	39	15	54	27	15	45
Foot Care	91	77	93	80	62	93
Instrumental Activities of Daily Living						
Shopping	91	69	100	100	92	100
Banking	83	54	85	89	83	97
Money Management	79	54	85	90	83	93
Preparing Meals	85	69	96	93	83	100
House Cleaning	96	73	96	100	100	100
Mental Status						
Awareness	16	4	43	20	21	50
Orientation	20	4	44	10	21	50
Memory	25	4	54	20	14	50
Judgement/Decision	17	12	42	22	21	53
Psychosocial Status						
Social Interactions	38	27	53	56	43	80
Agitation	14	12	21	5	0	27
Aggression	20	12	28	12	14	40
Wandering	6	4	14	5	7	13
Depression	19	4	38	10	21	17

Cohort: results from the last assessment of the elderly forming the present demonstration cohorts.
Group A: results from the multidisciplinary assessment done in November 1989, of persons that were then on the nursing home waiting list and subsequently registered to Single Entry Point enriched services.
Group B: results from the multidisciplinary assessment of persons whose names were put on the nursing home waiting list through the Single Entry Point process.

SUMMARY AND CONCLUSION

The pilot project made it possible to examine the effects of the Single Entry Point model on: the caseload handled by Family and Community Social Services; on nursing home waiting list; and, the characteristics of persons currently registered on this list. The studies carried out point to the following conclusions.

A. Effects of the model on the **caseload** handled by Family and Community Social Services:

- Over the year, the caseload increase in both pilot regions was greater than the increase in other regions. The increasing caseload is attributed to the Single Entry Point project for the following reasons:
    - elderly people who previously went to Public Health in order to be registered on the nursing home waiting list now are assessed by Community Social Services;
    - persons who used to be referred to other institutions or agencies because regular services were unable to meet their needs, now remain active cases;
    - at the beginning of the project, persons on the existing nursing home waiting list who qualified were registered for enriched services;
    - at the beginning of the project also, long-term care cases were transferred from Public Health to Extra-Mural Hospital.
- Although there was an increase in the number of intakes, there were fewer cases opened. There was a net decrease in the Fredericton pilot region (-17%) and a downward trend in the Péninsule acadienne region (-4%).
- The situation will have to be monitored over a longer period in order to determine which proportion of the increase in the caseload can be attributed to a case finding effect of the Single Entry Point.

B. The studies conducted concerning the impact of the model on the **nursing home waiting list** led to the following conclusions:

- There were fewer elderly persons on the waiting list on September 31, 1990 than on the same date the year before: 15 as compared to 92 in the Fredericton region, and 11 as compared to 60 in the Péninsule acadienne.
- Following the start of the project, the waiting list began to decline in November 1989 when the then-current cases were assessed.
- Since the end of December 1989, the size of the waiting list has been reduced by 84% in the Fredericton region (the actual number varying from 10 to 17) and by 76% in the Péninsule acadienne region (the actual number varying from 11 to 22).

- This reduction in the waiting list could have been larger if vacant beds had not been filled by persons from other ares of the province. Such admissions accounted for 26.3% of those in the Fredericton region and 10.5% in the Péninsule acadienne.
- The waiting period for nursing home admission was also reduced considerably. The average waiting period for cases referred by the Single Entry Point project during a six-month period was 18.6 days in the Fredericton region and 16.5 days in the Péninsule acadienne region.

C. Characteristics of the two groups of 30 seniors whose names were placed on the nursing home waiting list by the Single Entry Point panel (based on a compilation of data from the multidisciplinary assessment):.

- Persons in both groups were frailer than those receiving enriched services, for both pilot regions.
- The most striking difference between these groups and those receiving enriched services pertained to their mental health status.

Comparison between these two groups and two groups of elderly taken from the nursing home waiting list at the start of the Single Entry Point, who were given enriched services after assessment, leads us to conclude that:

- The elderly who are now registered on the nursing home waiting list through the Single Entry Point process appear more frail than those who were on the same waiting list at the onset of the pilot project.

This chapter has examined the effects of the Single Entry Point model on only two components of the long-term care system. The following chapter will identify the impacts of the model on other elements of the system of care for the elderly, for those who were partners in attaining the goals of the Single Entry Point model.

CHAPTER IX

OBSERVED AND PROBABLE IMPACTS, ACCORDING TO SINGLE ENTRY POINT PARTNERS AND STAKEHOLDERS

The Single Entry Point project has undoubtedly affected both the context and nature of the work performed by the partners to the project (nursing homes, service agencies, hospitals) and many professional associations and groups. This chapter seeks to identify the impact of the Single Entry Point model based not only on the observed changes but also the anticipated impact of the model.

A. OBSERVED IMPACTS

A questionnaire was sent to hospitals, nursing homes and service agencies from the Fredericton and Péninsule acadienne region concerning the changes observed after implementation of the Single Entry Point project. In the questionnaire sent to this group, each respondent was asked the following question:

> Please describe below the three main changes that you have observed in your institution or agency as a result of the Single Entry Point project, indicating what has changed, how much it has changed if possible, and if this impact seems, in your opinion, to be clearly negative, rather negative, or clearly positive.

The following analysis was prepared based on the responses received. Since this is a preliminary study of impacts, it is to be noted that all the impacts mentioned are listed below whether they were mentioned by a few or many respondents.

IMPACTS OBSERVED BY NURSING HOMES

A total of 14 of the 16 nursing homes (88%) located in the Péninsule acadienne and Fredericton regions returned questionnaires. The impacts observed by nursing homes during the trial period year of the Single Entry Point project have been grouped under five main headings:

Impact on the frail elderly residing in nursing homes - Two impacts were mentioned by several respondents and were considered to have a negative consequence. First, there was an overall decrease observed in the quality of the social life among the residents, due to the poor physical and mental health of new admissions - second, the number of transfers increased as individuals not admitted to the home of their choice asked for a transfer. For the resident, this meant a new period of adaptation. Several people also mentioned that the pilot project caused a marked decrease in the waiting list, an impact considered positive by some and negative by others.

- **Impact on human resources** - Half the respondents observed a lack of training among personnel. This impact was clearly perceived to be negative. It was noted that hiring criteria for personnel reflected the needs of the old clientele.

- **Impact on the tasks** - Most respondents observed an increase in work load: new admissions were mentally confused and required more supervision, more residents ate in their rooms, more residents required a higher level of care. In short, the number of hours of work per resident increased. This impact was considered negative.

- **Impact on the activities program** - A third of the respondents observed that the arrival of these new residents put limits on activity programs and brought about a need to develop new activities. This impact was considered negative.

- **Impact on costs** - Several people observed an increase in personnel and operating costs: special diets, laundry (incontinence), physical installations (runaways), wheelchairs, etc. An increase in the number of vacant day beds was also noted. These impacts were considered negative.

IMPACTS OBSERVED BY PERSONS REPRESENTING SERVICE AGENCIES

A total of 16 of the 22 service agencies (73%) located in the Fredericton and Péninsule acadienne regions returned questionnaires. The impacts observed these agencies during the trial period year of the Single Entry Point project have been grouped under five main headings.

- **Impact on personnel needs** - Most respondents stated needing more personnel, especially more housekeepers. The project created the need for a pool of employees. These impacts were perceived as positive.

- **Impact on roles and tasks** - Several people mentioned changes in the role of housekeepers. It was also noted that the Single Entry Point project required more case management. More is known about the kind of nursing care required and the extent of needs to be met. All these impacts were perceived as positive. However, one person mentioned that part-time housekeepers were being asked to be more involved, an impact which was considered negative.

Impact on personnel training needs - Half of the respondents mentioned personnel training needs but considered this to be a positive impact of the Single Entry Point project.

Impact on offered services - The variety of services offered and the demand for service by elderly persons increased. The scheduling of services had to be modified. There was an increased demand for psychiatric assessments. In one case the pilot project caused another service to be offered. Close to half of the respondents identified there was an impact on the services offered and considered these impacts positive.

- **Impact on housekeepers** - A few people remarked that the pilot project created more work for housekeepers; they considered this a positive impact. One person noticed an improvement in the housekeeper-client relationship because of decreased anxiety over the cost of service.

IMPACTS OBSERVED BY PERSONS REPRESENTING HOSPITALS

A total of 8 of the 10 hospitals (80%) located in the Fredericton and the Péninsule acadienne regions returned questionnaires.

From a clearly positive point of view, most respondents reported that frail elderly who were discharged from the hospital had quicker access to nursing homes or returned more quickly to home. These facts themselves had an impact: better use of hospital resources. One person observed that the elderly can do at home the things learned during rehabilitation. This impact was also considered positive.

A few people mentioned an increase in outpatients and the fact that the elderly were coming to the hospital only when needed.

B. EXPECTED OR PROBABLE IMPACTS

Expectations of the impact of the Single Entry Point project were identified by studying the description of the model, the documentation used in the project as well as listening to discussions on the model. To determine probable impacts, we described some of them (see Appendices E and F) and invited project partners to express their opinion on the scope of these impacts. A synthesis of the opinions expressed reveals where there was both consensus and differences in opinion.

New attitudes to be developed - The Single Entry Point model requires changes in attitudes since it makes use of a way of seeing things that is new for some people. Such attitudinal change was described for three groups: the general population, the elderly themselves , and the members of organizations and agencies involved in implementing the model.

> Statement on questionnaire - As a result of the Single Entry Point project, **the population in general and the elderly** in particular will have to understand the importance of accepting personal responsibility for their well-being and health.

The majority of respondents considered this impact would be great. They felt little had been done to teach about health and well-being and that there is considerable catchup to be done. Some comments indicated however that taking charge of one's health and well-being is more a question of physical and or mental capacity than a question of willingness or attitude.

> Statement on questionnaire - As a result of the Single Entry Point project, **members of organizations and agencies** involved with a frail elderly person will have to change their personal attitude and professional approach based on this clientele.

The respondents had differing points of view on this statement. The majority of nursing homes, service agencies and hospitals considered that this would have a large of very large impact. However, the majority of provincial associations and groups considered that this would be a rather weak, or at the most average, impact. The latter group remarked that positive attitudes already existed and professional development was also underway.

Change in clientele - Only provincial associations and groups were asked their opinion of this impact . We also invited other project partners to make known to us the changes they had observed in this matter, changes we have already noted in section A of this chapter.

> Statement on questionnaire - As a result of the Single Entry Point project, **community services** will see a clientele change.
>
> Statement on questionnaire - As a result of the Single Entry Point project, **institutions** (hospitals, nursing homes, etc.) will see a clientele change.

The majority of provincial associations and groups believed that the change in the community service clientele would be less noticeable than the change in the clientele of institutions. Some people noted that nursing homes would be caring for elderly people with greater needs than previously, and that hospitals and nursing service agencies would be faced with a greater demand for acute care. Also, in some cases, services specifically for the frail elderly would need to be developed.

Resources to develop and emphasize - One of the comments made will serve as an introduction: "...presently the needs are greater than the services available". (translation)

> Statement on questionnaire - As a result of the Single Entry Point project, **each region** will have or will develop a group of community services such as housekeeping, relief, meals, friendly visit, physiotherapy, occupational therapy services, etc. to meet the needs of the frail elderly.

The majority of respondents agreed that this impact will be great and for some regions very great.

A work model to strengthen: the multidisciplinary team - The multidisciplinary team is an essential element of the Single Entry Point model, a place for dialogue and decision-making.

> Statement on questionnaire - To meet its objectives, the Single Entry Point project requires that members of the community involved with the frail elderly (social workers, nurses, doctors, other health professionals, informal caregivers, etc.) form a **multidisciplinary team**.

The majority of respondents considered this impact to be large, if not very large. The participation of all people involved was desired, keeping in mind a concern for efficiency and the optimum use of time spent on the team.

OTHER PROBABLE IMPACTS ACCORDING TO PERSONS REPRESENTING ASSOCIATIONS AND GROUPS - The following question was included in the questionnaire addressed to provincial associations and groups.

> What, according to the members of your association, are the other probable impacts and what would be the effects of each?

Each impact listed below was mentioned only by one person. The five main headings indicate the areas where, according to the responding associations and groups, the Single Entry Point project will have the most impact.

- **Probable impacts on the elderly and their family** - There will be a change in expectations of the elderly and their children and, in the expectations of the general public. People who could benefit from the project will need information. Earlier intervention will result in physical problems involving mobility, strength, range of movement, coordination, pain etc., being identified and treated before they become disabling. By keeping their autonomy, clients will remain independent longer and have less need for services. Finally, a better quality of life for the elderly is predicted.

- **Impacts on human resources** - There will be increased work for occupational therapists in the community and nursing homes. There will also be an increase in the caseload of hospital based occupational therapists if these professionals are asked to be part of the multidisciplinary assessment team for clients who are hospitalized. In addition, there will be a change in the role of physiotherapists as they are called upon to provide consultation to beneficiaries and educators, interveners and informal caregivers. They will also become more involved in health promotion and education. A need for more training in geriatrics is also foreseen. Finally, there will a need for personnel to work hours other than 9 to 5.

- **Impacts on services** - There will be an increase in the demand for services, especially good quality and economical respite care and day care programs. Calls to the Alzeimer's society by family members for support and information about the disease are also expected to increase. Finally, the demand on health care equipment from agencies such as Red Cross, CRDC is expected to increase.

- **Impacts on costs** - Opinions on this subject were contradictory. On the one hand, some expected that a more autonomous elderly would need less services, which will reduce costs. On the other hand, an increase in the costs of equipment for rehabilitation and health care is predicted. Finally, budgets will need to be adjusted to meet this increase in demand.

SUMMARY AND CONCLUSION

Within the limitations of the evaluation, we did a preliminary study of the impact of the Single Entry Point model. This study enabled us to draw up two lists: one identifying the impacts observed during the test period of the pilot project, and a second indicating the probable or expected impacts.

Impacts already observed - Compilation of answers to questionnaires returned by 88% of the nursing homes, 73% of the service agencies and 80% of the hospitals of both pilot regions let us draw a list of the type of impacts these respondents have already observed. The type of changes identified by each group are presented below.

Observations of nursing homes:

- impact on the elderly residing in nursing homes;
- impact on human resources;
- impact on tasks;
- impact on activities program;
- impact on costs.

Observations of service agencies:

- impact on personnel needs;
- impact on roles and tasks;
- impact on personnel training needs;
- impact on services offered;
- impact on homemakers.

Observations of hospitals:

- impact on persons discharged;
- impact on use of hospital resources.

Expected or probable impacts - The list of expected or probable impacts was based on the project description of the Single Entry Point and on the opinions expressed by respondents representing nursing homes, service agencies, hospitals, associations, and groups. The following topics were discussed:

- new attitudes to be developed;
- expected change in clientele;
- resources to be developed and enhanced;
- work model to be strengthened: the multidisciplinary team;
- probable impact on the elderly and their families;
- probable impact on human resources;
- probable impact on services;
- probable impact on costs.

This chapter presented a descriptive study of the impacts of the Single Entry Point project on several components of the care and service systems. To determine the importance or the scope of the identified impacts, a more in-depth descriptive and quantitative study is needed.

CHAPTER X

OPINIONS ON THE SINGLE ENTRY POINT MODEL

The purpose of this chapter is to report on the opinions gathered between November 1990 and January 1991, from six different groups. Various techniques were used to collect the information from the six target groups.

- A sample of frail elderly persons in the demonstration cohort and informal caregivers were interviewed. Appendix C contains a parallel report on the interviews with both these groups.

- All social workers and nurses involved in the Single Entry Point project received a questionnaire asking their opinions on various aspects of the pilot. Appendix D contains a compilation of their answers and a synthesis of the comments made by the professionals.

- Hospitals, nursing homes, and service agencies in both pilot regions also received a questionnaire which focused on the following aspects of the Single Entry Point: project objectives, strengths of this approach, points to be improved. Appendix E contains a compilation of their answers and a synthesis of the comments made by the institutions and agencies.

- A similar questionnaire was sent to associations and groups identified as stakeholders. Appendix F contains a compilation of the answers received and a synthesis of the comments made.

- A series of interviews were conducted with the administrators of Single Entry Point in the two pilot regions.

The chapter first reports on client satisfaction and the opinions held by professionals of the Single Entry Point. The focus then shifts to the three items on which all of the above individuals and groups were asked to comment: agreement on the objectives of the Single Entry Point, the strengths of this approach, and the improvements that should be made to it.

A. CLIENT SATISFACTION

SATISFACTION WITH THE SERVICES RECEIVED (Appendix C) - Answers of elderly in both cohorts indicated that over 97% of them indicated they were very satisfied with the services they received. The services being received by the frail elders interviewed included primarily homemaker services, nursing care, in-home relief services, meal services, and specialized equipment services. In addition, 77% of the respondents from the Fredericton cohort and 84% of those from the Péninsule acadienne cohort said that the services received did not disrupt their lifestyles at all.

Of the informal caregivers who were asked the same question on satisfaction with the services provided, over 97% of them also said they were very satisfied. Moreover, 96% of informal caregivers surveyed from the Fredericton cohort and 76% of the ones from the Péninsule acadienne cohort said that the services provided did not disrupt their lifestyles at all. According to them, the services provided made life easier for the people involved, and enhanced the quality of life of seniors.

TIME AND PROCEDURES FOR OBTAINING SERVICES (Appendix C) - On the whole, 85% of the people questioned said it took them little or very little time to get services (88% of the elderly and 85% of the informal caregivers) and were quite or even very happy to have taken the necessary steps (84% of the elderly and 88% of the informal caregivers).

REACTION TO THE ASSESSMENT: THE PROFESSIONALS' PERCEPTIONS (Appendix D) - In answer to the question on their perceptions of the client's reaction to the assessment, 39% of professionals said they had perceived average or great **anxiety** among the elderly who were assessed, and 30% noticed the same degree of anxiety among the informal caregivers interviewed. Not many professionals said they perceived irritation with the multidisciplinary assessment: only 15% of professionals perceived an average or large amount of **annoyance** among the frail elders who were assessed, and 22% found the same degree of annoyance among the informal caregivers interviewed. A large number of professionals noticed a high level of **satisfaction** with the multidisciplinary assessment: 78% of professionals reported they perceived average or great satisfaction among both the elderly who were assessed and the informal caregivers interviewed.

MATCHING SERVICES WITH NEEDS AND PREFERENCES (Appendix C) - In the Fredericton cohort, 14% of the frail elderly questioned said they had participated quite a bit or a lot in decision-making regarding the services being received; in the Péninsule acadienne cohort, 48% said they had participated quite a bit or a lot. Yet almost all of the frail elderly interviewed, more than 90% in each cohort, said that the services they were receiving were well or even very well suited to their needs.

In the Fredericton cohort, 19% of the frail elderly interviewed said they often or very often stated their preferences; in the Péninsule acadienne cohort, 43% said so. Those who said they made their preferences known rarely or not very often either did not consider it necessary, were satisfied with the situation, or else relied on their informal caregivers in this matter.

A different situation emerged when the informal caregivers' answers to the same questions were analyzed. A larger number of respondents in each region (Fredericton: 38%; Péninsule acadienne: 80%) said they had participated quite a bit or a lot in the decisions regarding the services that were provided. In each region, more than 80% thought the services to be well or even very well suited to their needs. While only 44% of the informal caregivers interviewed in Fredericton said they had indicated their preferences, most of the others said they had not done so because the services as such were satisfactory and there was no need to take action. In the Péninsule acadienne, 76% of the informal caregivers said they had often made their preferences known.

INVOLVEMENT IN DECISION-MAKING: THE PROFESSIONALS' PERCEPTIONS (Appendix D) - When asked for their opinion on what percentage of frail elderly were able to be involved in making the decisions concerning them, 22% of professionals said between one half and three quarters of seniors, while 42% said that over three quarters of the frail elderly had a say in the decisions concerning them.

When asked what proportion of informal caregivers were able to be involved in the decisions concerning them, 26% of professionals said between one half and three quarters of the informal caregivers, and 49% of professionals said that over three quarters of the persons were able to be involved in decisions concerning them.

Most frail elderly considered the Single Entry Point a positive or very positive experience: 82% of those interviewed in the Fredericton area (18 out of 22) rated the Single Entry Point as a positive or very positive experience for them, and 90% of those in the Péninsule acadienne region (17 out of 19) felt the same way.

B. SINGLE ENTRY POINT FROM THE VIEWPOINT OF SOCIAL WORKERS AND NURSES (Appendix D)

PROCESS AND PROCEDURES - None of the professionals said they were currently encountering very much difficulty with any of the three stages of the multidisciplinary assessment after a year of implementation. Most professionals (74%) had minimal or average difficulty assessing a case. For most professionals (76%) developing the service plans represented minimal or average difficulty. Finally, 80% of the professionals found presentation to panel to be of minimal or average difficulty. The difficulties emphasized included not enough time to do a satisfactory job; difficulty in synthesizing the large amounts of information obtained from the multidisciplinary assessment; and, the problem in some cases of assessing needs correctly on the basis of a single visit.

The situation was somewhat different for the next two stages in the process: implementing of the service plan and providing follow-up. For most professionals (80%), implementing the plan represented minimal or average difficulty. Although their comments indicated that sometimes it was very difficult to find services suitable for a particular situation, following up on the service plan proved to be the most difficult stage. More than half of the professionals (62%) said that difficulty in following up on the service plan was low or average and 35% said the difficulty of this stage was great or very great. Their comments indicated difficulty, if not impossibility, of carrying out this stage. An excessively heavy workload combined with the obligation to deal with other priorities meant there was not enough time to spend on the follow-up.

IDENTIFICATION OF NEEDS THROUGH THE MULTIDISCIPLINARY ASSESSMENT - More than half of the professionals (56%) experienced great or very great satisfaction with the multidisciplinary assessment in determining seniors' real needs. A large proportion of the information gathered in the evaluation was considered helpful for properly identifying the needs of the elderly and drawing up satisfactory service plans: 29% of professionals said that 60 - 80% of the information was helpful, and 34% of them said that over 80% of the information was. According to 50% of professionals, the results of this assessment (amount and quality of the information obtained etc.) justifies generally, or even fully, the time and energy spent on the multidisciplinary assessment.

THE EDUCATIONAL ASPECT OF THE APPROACH - Maintaining or increasing the independence of the frail elder may mean in some cases teaching them new ways to take care of themselves or for caregivers, new ways of performing caregiving functions. Many professionals (almost 50%) were unable to answer the questions about what percentage of the elderly and the caregivers were learning new ways of doing things. Their answers suggest that a greater percentage of caregivers learned new ways of doing a better job than elderly, with respect to their own personal care.

THE MULTIDISCIPLINARY APPROACH - When asked to indicate one or two factors that interested or helped them the most, 70% of professionals mentioned the multidisciplinary approach. According to them, this approach made it possible to learn, understand, get a broader view of the situation, and specify comparable expectations. Most professionals interviewed (69%) had the impression of belonging to a multidisciplinary team. Several of them (54%) considered the actual sharing of responsibilities rather effective. Let us note that training sessions throughout the pilot period of the project regularly brought the members of the multidisciplinary team together: social workers, nurses and other professionals involved.

COORDINATION AND ITS IMPROVEMENT - Most comments referred to coordinating the work of the multidisciplinary team. At the time they were questioned, each person knew more about what the other team member did. The assessment of a case and preparation of the service plan were considered the main mechanisms for coordination. Great willingness to accomplish tasks was observed, but the big problem was getting them done. The main problems noted were the work schedules of Extra-mural Hospital workers as well as their other responsibilities, particularly responsibility for intensive care patients.

THE CASE MANAGEMENT APPROACH - The professionals considered a wide variety of duties to be part of the case management approach: attending a case conference, guaranteeing follow-up on the service plan, coordinating services, managing things for the client (providing information and advice), counselling, recommending, etc. From the professionals' point of view, this approach did not appear to be unique to the Single Entry Point model. More than 50% of respondents judged the question concerning tasks related to the case management approach to be unnecessary or were not able to answer it.

C. AGREEMENT ON THE OBJECTIVES OF SINGLE ENTRY POINT

Opinions of the frail elderly (Appendix C) - According to the information gathered from interviews with 41 frail elderly in the current demonstration cohorts, most said they agreed with the objectives of the Single Entry Point. In each region, over 88% of them quite a bit and even fully agreed with the idea that the program is trying to protect the independence of seniors and enable them to take better care of themselves. The program's intention to not offer services that the elderly can provide for themselves was also well or very well accepted by 91% of the elderly interviewed in Fredericton region and by 79% of those interviewed in the Péninsule acadienne region.

In the Fredericton area, 77% of frail elders questioned thought this type of program was really necessary to enable seniors who wish to live at home to do so; 68% of the same elderly said they wanted to live at home for a long time yet. In the Péninsule acadienne area, 90% of the elderly questioned shared the opinion that this type of program was really necessary; 85% of them said they wanted to live at home for a long time yet.

Opinions of informal caregivers (Appendix C) - On the basis of the information gathered during interviews with 49 informal caregivers, it was found that most said they agreed with the objectives of the Single Entry Point: 79% of informal caregivers of the Fredericton region and 91% of those of the Péninsule acadienne agreed quite a bit or fully with the idea that the program is trying to protect the independence of the elderly and make them capable of taking better care of themselves. The program's intention of not offering services that the elderly can provide for themselves was well or very well accepted by more than 82% of those questioned in each region. Also, over 80% of informal caregivers thought this type of program was necessary to enable seniors who wish to live at home to do so. During the trial year, 75% of the group of Fredericton and 84% of the group of the Péninsule acadienne said that they considered the Single Entry Point a positive or very positive experience.

Professionals' opinions of the Single Entry Point Model (Appendix D) - According to the information obtained by questionnaire from the professionals (social workers and nurses), move than half of Single Entry Point professionals (55%) thought the pilot project approach satisfied the needs of the frail elders who wish to live at home rather well, while 27% thought it satisfied those needs very well. The 63% of respondents who indicated Single Entry Point project satisfied their professional expectations emphasized that every aspect of the project made it enhancing from the professional standpoint.

Opinions of persons representing hospitals, nursing homes and service agencies participating in the Single Entry Point pilot project (Appendix E) - On the basis of information obtained through questionnaire sent to 38 people representing hospitals, nursing homes, and service agencies participating in the Single Entry Point pilot project, we found that, on the whole, there was wide agreement on the objectives of the Single Entry Point. Over 70% of the respondents agreed generally or fully with the objectives of maintaining the independence of the frail elderly, of maintaining or increasing the ability of frail elders to take care of themselves and of involving frail elders and their informal caregivers in the decisions concerning them, all objectives related to the same goal: arrive at the decision to enter a nursing home (institutional environment) only after all the possibilities available in the community have been exhausted. A few said effort must be made to leave the decision up to the frail elder, not to pressure them one way or the other but to try to find out what they really want. They also said that the services offered must be available 24 hours a day, seven days a week.

On the other hand of all the objectives listed maintaining or increasing the informal caregiver's capacity received the least support - sixty-six percent (66%) of those responding agreed generally or fully with that. A few mentioned that, here too, effort must be made to really find out the wishes and desires of the persons involved. Also, the capacity of the informal caregiver must be taken into consideration. Five persons said that the project could or should do more for these people.

Opinions of persons representing associations or groups identified as stakeholders in the Single Entry Point (Appendix F) - Over 82% of the 12 stakeholders who answered the questionnaire agreed generally or fully with the objectives.of maintaining the independence of the frail elderly, of maintaining or increasing the ability of frail elders to take care of themselves and of involving frail elders and their informal caregivers in the decisions concerning them, all objectives related to the goal of arriving at the decision to enter a nursing home (institutional environment) only after all the possibilities available in the community have been exhausted.

A few comments stressed that achieving the objectives of the Single Entry Point will depend on the availability of the services proposed by the model, better knowledge of the needs of informal caregivers and better support for key people in the model.

We can say that in general the people, agencies or groups who gave their opinions as part of the project's evaluation agreed with the objectives of the project. The main reservations expressed dealt with the importance of leaving the decision up to the elderly and their informal caregivers, the importance of knowing the informal caregivers better and giving them better support, and finally, the tremendous importance of having a wide range of services available at all times.

D. THE STRENGTHS OF THE SINGLE ENTRY POINT

Opinions of the frail elderly (Appendix C) - No one aspect of the Single Entry Point was singled out as positive by a large number. Experiences varied. For the frail elders who were questioned, living at home (mentioned 7 times), having company (6 times), being able to get around on their own (4 times) and feeling secure (3 times) were all rated positive.

Opinions of informal caregivers (Appendix C) - From the standpoint of informal caregivers receiving assistance (mentioned 22 times) of high quality (6 times), benefiting from in-home relief service (6 times) and benefiting from special equipment (3 times) were all rated positive. One positive experience shared by many (mentioned 15 times) was the sense of security and peace of mind produced by the changes brought about through Single Entry Point such as having someone with whom to share the responsibility and discuss problems. Three people said they appreciated the extra freedom it gave them.

Professionals' opinion of the Single Entry Point (Appendix D) - While the questionnaire did not directly ask professionals about the strengths of the Single Entry Point it should be pointed out that several found the multidisciplinary approach an interesting aspect of the Single Entry Point. Similarly, the fact was emphasized that the pilot project offered many frail elderly a viable alternative to a nursing home.

Opinions of persons representing hospitals, nursing homes and service agencies participating in the Single Entry Point pilot project (Appendix E) - Many respondents said that Single Entry Point gave frail elders who so wish to continue living at home (mentioned 14 times) the chance to do so. The number of options and services available was singled out as a strong point of the Single Entry Point (9 times). Access to a more complete assessment (8 times) and improved coordination through the multidisciplinary team (7 times) were also pointed out as strengths of the Single Entry Point. Some positive effects of the project which were mentioned included: a shorter waiting period before admission to a nursing home (3 times) and better use of the resources and space available in hospitals and nursing homes (3 times).

Opinions of persons representing associations or groups identified as stakeholders in the Single Entry Point (Appendix F) - The strengths identified by the 12 stakeholders answering the questionnaire fit into three categories: autonomy of the elderly, multidisciplinarity and community spirit. It was stressed that giving the elderly a chance to stay in their family and social environments for as long as possible also means protecting their independence and human dignity. Many of the strengths they identified were professional in nature: the holistic approach provided by the multidisciplinary assessment; a noticeable improvement in coordination and assessment resulted in, among other things, better use of the financial and human resources in the community, in nursing homes, and in hospitals. One person stressed that the Single Entry Point boosted community spirit: everyone tried to offer a full range of services to attain the objectives.

Opinions of Single Entry Point administrators (Appendix G) -The opinions of this group emphasized five positive aspects of the Single Entry Point. First, they stressed that the model represents a real alternative to nursing homes for those who want to continue living at home and that interventions to maintain the independence of the frail elderly are possible. Next, they mentioned that access to more financial resources through the project is essential because it gives them the leeway they need to draw up adequate service plans.

Another strong point of the project is case management - a case is considered the responsibility of one professionals on the multidisciplinary team.

The multidisciplinary approach is considered a major asset of the model: many decisions are made by the team, doctors involved give their elderly patients additional support, consulting with specialists (occupational therapists, physiotherapists, mental health specialist etc.) is encouraged, and the elderly and their informal caregivers are involved. The multidisciplinary approach also gives each professional a chance to expand his or her field of observation by gradually incorporating the view of another discipline. Thus, an observation made during a visit may prompt a professional to contact their counterpart to give a brief report and perhaps suggest a form of intervention. The multidisciplinary approach creates new challenges for the professionals involved by putting them in a situation where they are questioned by their peers.

Another strong point stressed was the multidisciplinary assessment tool using a common instrument facilitates communication. This is particularly noticeable in the field of mental health. The instrument motivated the professional to pay attention to a wide range of factors, despite being pressed for time, and to expand their analyses.

In summary - On the whole, respondents agreed that in some cases the model really does offer the frail elderly who wish the chance to live at home longer than they had expected. Generally speaking, the multidisciplinary approach was considered central to the model. The assessment was thought to be more thorough and of a higher quality than in the past. The scope of the service options offered by the Single Entry Point was also mentioned as a strong point, even though progress must be made in making them available around the clock for anyone who needs them. Furthermore, a few associations or groups noted better coordination in the delivery of services and better use of resources as positive effects.

E. IMPROVEMENTS

A question on improvements to be made was asked in interviews with the elderly and persons designated as informal caregivers. The question was also included in the questionnaires sent to nursing homes, service agencies, and hospitals, as well as to stakeholders. This first set of answers to this question were informative about the respondents' perceptions of Single Entry Point, whether as clients or as social partners.

On the other hand, the same question about potential improvements was put directly to Single Entry Point administrators and although it was not included in the direct questions sent to professionals, several suggestions for improvements were contained in the comments received. This second set of answers revealed the perceptions of the principal agents of implementing the Single Entry Point. Because they reflect different points of view, the two sets of suggestions are presented separately below.

IMPROVEMENTS DESIRED BY CLIENTS AND SOCIAL PARTNERS

Opinions of the frail elderly (Appendix C) - The negative experiences noted involve specific problems encountered during the year - a few seniors (mentioned 8 times) said they had difficulty with homemaker services, especially during the first visit.

Opinions of informal caregivers (Appendix C) - The negative experiences noted here also involved specific problems encountered during the year: lengthy and difficult procedures (mentioned 3 times), lack of nursing support during a crisis (once), lack of consultation regarding a change of homemaker (once), departure of the person providing in-home relief before the caregiver returned (once), absence without notice (twice). One person worried about whether the project would last. Another said that caregiving took up a lot of time. Two informal caregivers said they were often worried. Three indicated that refunding of the money paid for various services took too long.

Each of the following points was mentioned once as a potential improvement: a psychologist who makes house calls; access to a physical exercise program at home; improvement in follow-up on services; access to services on weekends. One person wondered why we do not pay people who spend their time taking care of an elderly person in the family. Two people worried about the impact of the very low salary paid to homemakers. Another mentioned the importance of criteria when recruiting and hiring homemakers.

Opinions of persons representing hospitals, nursing homes, and service agencies participating in the Single Entry Point pilot project (Appendix E) - Several suggestions on how to improve the operation of the Single Entry Point were made. The following are the main points that emerge from their comments as a whole.

- INFORMAL CAREGIVER: Clearly assess the impact of Single Entry Point on the informal caregiver and act accordingly.

- ASSESSMENT: Provide a better mental health assessment.

- SERVICE OPTIONS: Ensure that services are available day and night, as well as weekends.

- HOMEMAKER'S SITUATION: Find ways to improve the situation of homemakers, and in so doing, the service offered: a guaranteed block of 35 to 40 hours per week, additional training, extra pay for work outside regular hours or on weekends.

- RESOURCES: Take into consideration the impact of Single Entry Point on institutions and make the necessary adjustments in terms of resources and environment.

- TIME: Complete the assessment and administrative process as quickly as possible.

- COMMUNICATION: Establish a standard method of communication, especially with service providers and distinguish clearly between informing, motivating, and forcing: when all is said and done, it is the individual who should make the choice.

Opinions of persons representing associations or groups identified as stakeholders in the Single Entry Point (Appendix F) - This group of respondents provided many suggestions for improving the operation of Single Entry Point. The following are the main points that emerge from their comments as a whole.

- CLIENTS:: Make sure the decision of the elderly and their informal caregivers is respected.

- ASSESSMENT:
  - Strengthen multidisciplinary cooperation.
  - Make assessors more aware of the problems of the very old.
  - Use observation rather than questioning to assess the functioning capacity of seniors.
  - Have specialists assess their functioning capacity.
  - Indicate on the assessment form the need for referral to specialized assessment.
  - Let occupational therapists assess mobility and abilities in everyday activities.

- SERVICE OPTIONS:
  - Make sure that a full range of services are available in each region, including geriatric assessment and day care centers.
  - Make existing services available throughout the region.
  - Make services available at all times : 24 hours a day, 7 days a week.
  - Offer in-home mental health service.

- RESOURCES: Help (primarily funding) associations establish and coordinate self-help groups.

- TIME: Make the procedure less time-consuming.

- COMMUNICATION:
  - Improve communication between the Single Entry Point team and the attending physician. Involve the family doctor in the entire process.

- Develop a mechanism, such as a form, to refer the case to a physician highlighting the urgency and purpose of the referral.
- Increase involvement of service agencies in the project; involve them from the start.
- Inform formal or informal caregivers of the special needs associated with certain states of health, such as Alzheimer's disease.

IMPROVEMENTS DESIRED BY SINGLE ENTRY POINT IMPLEMENTATION AGENTS

Many suggestions for improvement were made by the professionals and administrators, principal agents of the implementation of the Single Entry Point model.

The opinions of the professionals (Appendix D) - The questionnaire to social workers and to nurses did not include specific questions concerning areas to be improved in the Single Entry Point process. Nevertheless, two main points can be identified which were supported by a large number of professionals.

- LACK OF TIME: Even after a year of trial and being more at ease with the forms and procedures, having time to correctly accomplish the necessary tasks is still a problem.

- DIFFERENCES IN WORK SCHEDULES: The social workers schedule is different from the Extra-Mural Hospital workers' schedule. Thus making contact with the other member of the multidisciplinary team or arranging meetings are difficult tasks to perform.

It should be noted that the demands for supplementary information within tight deadlines for the purpose of the pilot project evaluation could have had an effect on the lack of time reported here. The time study (see Chapter VII) should be pursued in order to be more certain of the model's impact on the amount of time available to a client.

The opinion of administrators - During interviews with six people from the Fredericton region and seven from the Peninsule acadienne region (coordinator for the pilot project and supervisors in the social agencies and the Extra-Mural Hospital), each was asked for suggestions for improvements. The desired improvements were grouped under five themes: structure, multidisciplinary team, assessment, panel and resources.

- STRUCTURE: The issue of structure was relevant for both regions. In lights of the present structure, Single Entry Point cannot be the sole responsibility of the Department of Health and Community Services, as it depends on the full participation of the Extra-Mural Hospital. This trial period year has led to the conclusion that the pilot project worked despite the structure, because of the unequaled commitment of each and everyone.

  The structure adopted following implementation of the project caused a series of problems; some of which were resolved or worked around, others were left unresolved. The following are examples of problems stated by the administrators of the pilot project:

  - more than one entry point: we can not really speak of only one entry point - this has caused coordination and communication problems especially since the computerized register is not yet fully working (RPSS);

  - the main members of the multidisciplinary team (social worker and health care worker) have their offices in separate buildings which are often a fair distance from each other - this was mentioned by almost everyone as causing communication problems (difficulties in reaching each other on the telephone, in making appointments and exchanging documents, the number of times that required leaving the office, etc.) - this also has caused coordination problems and increased the time needed for a case;

  - differences in subdividing the regional map meaning one social worker working with several health care workers - this has added to the usual difficulties of team work;

  - scheduling differences between the social worker and health care worker - on the one hand, a work day (8 hours for 5 days), on the other hand, a 24 hour schedule (24 hours for 7 days) - this has caused communication and coordination difficulties (case presentation to the panel, participation in training sessions, etc.);

  - differences in the legal requirements regarding clients files - the Public Hospitals Act stipulates requirements that the Single Entry Point project must eventually meet.

This was the situation during the trial period year. The people involved are asking for changes in this aspect of the Single Entry Point project.

- MULTIDISCIPLINARY TEAM: Other than improvements in the operation of multidisciplinary teams and the above-mentioned communication problems, three other areas for improvement were mentioned by the administrators: they wished to use more often the possibility of including occupational therapists, physiotherapists and respiratory technologists as members on the multidisciplinary team; they also desired to improve communications with doctors and facilitate contacts with them.

  Generally speaking, administrators believed that common training was essential to adequately build a multidisciplinary team. During the trial period, training sessions were organized every 4 to 6 weeks. They wish to continue this training with an expanded multidisciplinary team. They are looking for ways of working with doctors to encourage them to consider and choose the options available for frail elderly persons who wish to continue living in their home.

- ASSESSMENT: The issue remains of knowing which professional will fill out which part of the assessment form. The decisions made up to now have not been unanimous. Some wish a more complete assessment of social and family dynamics. Others consider that the information gathered on the "daily routines" and the "key activities of daily life" is basic data that a non specialized person can gather or, on the contrary, that this data should be gathered by occupational therapists since they are often problems allowing for intervention. Overall, better solutions are being sought.

  On the other hand, they wish to better equip themselves to interpret the overall observations made during the assessment. A guide for using the form in which this aspect of the assessment will be emphasized is expected.

- THE PANEL: After the year long trial period, the panel is considered to be a place to obtain additional expertise to fully consider all the options, a place to establish official contact with agencies, doctors, etc., and a place to confirm decisions. There is a desire on the panel to maintain a balance between the health and social aspect. There is also a desire to put procedures in place which will facilitate both preparing for the meetings and running them.

- RESOURCES: The lack of personnel was felt from the beginning of the pilot project. The administrators wanted this to be foreseen and corrected before implementation of the Single Entry Point project in another region of the province. They also wanted to establish working procedures with hospitals and nursing homes to facilitate meeting the objectives of the Single Entry Point project. They wanted the provisions of the Nursing Home Act to be revised for instance to take into account the demand for temporary respite places. Overall, the volume of requests for services surpassed the capacity of services agencies. Consequently, they noted a great need to develop these resources.

SUMMARY AND CONCLUSION

CLIENT SATISFACTION

- Almost all frail elderly and informal caregivers reported a very high degree of satisfaction with the services received.
- A very large number of persons said that the services fit in well with their lifestyles.
- A very large number of persons reported they spent little or very little time obtaining services and were glad they had made the necessary effort.
- A high degree of satisfaction with the multidisciplinary assessment was reported by a large number of professionals. Moreover, few professionals perceived any concern and very few perceived any annoyance on the part of clients with the multidisciplinary assessment.
- A very large number of frail elderly indicated the Single Entry Point had been a positive or very positive experience for them.

THE SINGLE ENTRY POINT PROJECT, FROM THE STANDPOINT OF THE SOCIAL WORKERS AND NURSES

- None of the professionals reported (in November 1990) a very high degree of difficulty with any of the three steps in the multidisciplinary assessment process.
- For a large number of professionals, implementation of the plan presented low or medium difficulty.
- Monitoring the service plan proved to be the most difficult step: lack of time, obligation to meet other priorities, etc.
- More than half of the professionals expressed a great or very great degree of satisfaction with the multidisciplinary assessment process for identifying the needs of seniors.
- A large percentage of information from the assessment was deemed useful in identifying the needs of the elderly and preparing a truly adequate service plan.
- According to half of the professionals, the results of the multidisciplinary assessment (quantity and quality of information obtained, etc.) justified rather well or even perfectly the time and energy required.
- Close to half the professionals were unable to answer the questions concerning the percentage of elderly and caregivers who learned new ways of doing things.

- The answers obtained suggest that the number of caregivers who learned new ways to better assume their caregiving role was higher than the number of seniors who learned new ways to better care for themselves.
- When asked to indicate one or two elements that interested or helped them the most, 70% of the professionals mentioned the multidisciplinary approach.
- Most professionals (69%) indicated that they felt a part of a multidisciplinary team.
- More than half thought that the present system of sharing responsibilities was adequate.
- At this stage of the project, each of them had a better understanding of what the other did.
- The professionals considered assessment, evaluation and care planning to be the principal mechanisms of coordination.
- They considered very diverse activities to be related to the case management approach: case conference, follow-up, counselling, etc. The professionals did not believe this approach was specific to the Single Entry Point model.

AGREEMENT WITH SINGLE ENTRY POINT OBJECTIVES

The objectives of the Single Entry Point model met with widespread agreement on the part of the persons, agencies, and groups questioned during the evaluation of the pilot project. The main reservations mentioned concerned the importance of giving the elderly and their informal caregivers a choice, the importance of knowing and supporting the informal caregivers better and the need for a wide range of service options being available at all times.

OPINIONS OF THE FRAIL ELDERLY

- More than 90% of frail elders agreed quite a bit or completely with the idea that the project sought to protect the autonomy of seniors and make them better able to take care of themselves.
- The philosophy of the project to offer only those services that people could not provide for themselves was accepted quite well or very well by 79% of the seniors.
- In the Fredericton region, 77% of frail elders believed that such a project was truly necessary in order to enable seniors wishing to remain in their homes to do so; in the Péninsule acadienne region, 90% shared this opinion.
- It appears that the desire to remain in one's own home is stronger in the Péninsule acadienne region, with 85% expressing such a wish, than in Fredericton, where 68% (15 out of 22) said they wanted to stay in their homes longer.

OPINIONS OF THE INFORMAL CAREGIVERS

- Nearly 80% of informal caregivers agreed quite a bit or completely with the idea that the project sought to protect the autonomy of the elderly and make them better able to take care of themselves.

- The philosophy of the project to offer only those services that people could not provide for themselves was accepted quite well or very well by more than 80% of those questioned.

- In addition, over 80% of informal caregivers believed that such a project was truly necessary in order to enable seniors wishing to remain in their homes to do so.

OPINIONS OF THE SINGLE ENTRY POINT PROFESSIONALS

- A very large number of Single Entry Point professionals believed that the pilot project's approach made it possible to meet the needs of frail elders wishing to remain in their homes adequately or very well.

- A large number of professionals indicated that all aspects of this project had met their professional expectations.

OPINIONS OF HOSPITALS, NURSING HOMES, AND SERVICE AGENCIES PARTICIPATING IN THE SINGLE ENTRY POINT PILOT PROJECT

- Over 70% of representatives who completed the questionnaire indicated they agreed quite a bit or very much with the overall objectives.

- A few reservations: give the seniors a choice, don't force them, try to really find out what they want, make sure the services offered are available 24 hours a day, 7 days a week; and, take into account the abilities of the informal caregiver.

OPINIONS OF ASSOCIATIONS OR GROUPS IDENTIFIED AS SINGLE ENTRY POINT STAKEHOLDERS

- More than 82% of stakeholders who responded to the questionnaire indicated they agreed quite a bit or very much with the overall objectives.

- A few comments: attainment of Single Entry Point's objectives depends on the complete availability of the services proposed by the model; need for greater knowledge of the needs of the informal caregivers; and, greater support for these key persons.

STRENGTHS OF THE SINGLE ENTRY POINT MODEL

Common elements emerge from the answers obtained when respondents were asked to describe two of the strengths of the Single Entry Point. Overall, they agreed that:

- The model succeeds in offering frail elders the opportunity to remain in their homes longer than they they anticipated, in some cases;
- The multidisciplinary approach is a focal point of the model;
- The assessment process is more complete and higher in quality than before;
- The range of service options offered is another strong point of the model, even though work needs to be done in order to make them available at all times and to everyone who needs them;
- The model promotes better coordination of the services offered, and thereby, better use of the resources.

OPINIONS OF THE FRAIL ELDERLY

- For the frail elders questioned, remaining in their own homes, making contacts with other persons, being able to get around by themselves once again, and a feeling of security are some of the positive elements brought about by the Single Entry Point.

OPINIONS OF THE INFORMAL CAREGIVERS

- From the standpoint of caregivers, receiving high-quality assistance, benefiting from a relief service, and access to rehabilitation equipment are among the positive elements.
- One strong point mentioned several times is the feeling of security and peace of mind resulting from the changes brought about by the Single Entry Point project: having someone with whom one could share responsibilities and discuss problems.

OPINIONS OF THE SINGLE ENTRY POINT PROFESSIONALS

- The multidisciplinary approach was singled out by many as a worthwhile aspect of the Single Entry Point.
- The fact that the pilot project offers many frail seniors a viable alternative to a nursing home was emphasized several times.

OPINIONS OF HOSPITALS, NURSING HOMES, AND SERVICE AGENCIES PARTICIPATING IN THE SINGLE ENTRY POINT PILOT PROJECT

- Several respondents indicated that Single Entry Point gives frail elderly persons who wish to continue living in their own homes a real opportunity to do so.
- The large number of options and services available was mentioned as a strong point of the Single Entry Point.
- Provides access to a more complete assessment.
- Better coordination of services by means of the multidisciplinary team.

OPINIONS OF ASSOCIATIONS OR GROUPS IDENTIFIED AS SINGLE ENTRY POINT STAKEHOLDERS

- Gives frail elders the opportunity to remain in their family and social environments as long as possible and thereby preserve their autonomy and their individual human value.
- Multidisciplinary assessment promotes a holistic approach and is a strong point of the model.
- Better coordination and assessment ensures better use of financial and human resources in the community, nursing homes, and hospitals.

OPINIONS OF SINGLE ENTRY POINT ADMINISTRATORS

- The model offers a real alternative to nursing homes for those who are interested.
- Actions to support the autonomy of frail elderly persons become possible.
- Access to more financial resources through the project provides the necessary latitude to develop an adequate service plan.
- Another strength of the project lies in case management, where one or another of the multidisciplinary team professionals takes the responsibility to case manage each case .
- The multidisciplinary nature of the model is considered a major asset.
- The common terminology used in the multidisciplinary assessment instrument facilitates communication.
- The instrument focuses attention on a wide range of elements; despite the fact that one is pressed for time, it promotes a more in-depth analysis.

IMPROVEMENTS THAT NEED TO BE MADE

As various responses on the question of improvements are complementary, the following summary groups the suggested improvements by heading rather than by the source of the comment. The improvements relate to both structure and operations.

STRUCTURAL IMPROVEMENTS

- The question of structure came up in both regions; the pilot project functioned despite the current structure, because of the unparalleled commitment of various parties.
- Because of the structure adopted after the project was implemented, a series of problems arose; some were resolved or circumvented, while others remained unsettled.
- The persons involved would like to see changes concerning this aspect of the model.

OPERATIONAL IMPROVEMENTS

The desired operational improvements concern the Single Entry Point approach and the components essential to implementation of the model: resources, services, and communications.

THE SINGLE ENTRY POINT APPROACH - THE ASSESSMENT

- Strengthen multidisciplinary cooperation:
    - on the multidisciplinary assessment form, highlight the indicators that point to a need for referral for specialized assessment;
    - use specialist to assess functional capacities;
    - ensure a better mental health assessment.
- Have better tools for interpreting the observations:
    - make assessors more aware of the problems of the very elderly;
    - have a user guide for the form which emphasizes the interpretation aspect.

THE SINGLE ENTRY POINT APPROACH - THE PANEL

- Maintain a balance on the panel between the health and social aspect.
- Establish procedures to facilitate preparation for meetings and the actual meetings themselves.

IMPLEMENTATION OF THE SINGLE ENTRY POINT APPROACH - THE SERVICES

- Offer an in-home mental health service.
- Make existing services available throughout the entire region.
- Make services available at all times: 24 hours a day, 7 days a week.
- Ensure a complete range of service options, including geriatric assessment and day centers, are available in each region.
- Find ways to improve the situation of homemakers, and thereby, the service offered.

IMPLEMENTATION OF THE SINGLE ENTRY POINT APPROACH - THE RESOURCES

- Emphasize the development of resources.
- Continue implementing linkage procedures with the persons, units, or agencies concerned.
- Make the adjustments needed to human resources.
- Make the adjustments needed to financial resources.
- Make the process more economical from the standpoint of the time involved.

IMPLEMENTATION OF THE SINGLE ENTRY POINT APPROACH - COMMUNICATIONS

- Maintain a distinction between informing, motivating, and compelling; thus allowing seniors and the informal caregivers to have a choice.
- Emphasize the establishment of effective communication ties.
- Continue the joint training required to build and maintain the multidisciplinary team.

Opinions were given regarding improvements needed in the Single Entry Point model in reply to open questions. The suggestions or comments expressed reveal the overall importance attached to values such as respect for individuals, participation, professional quality of the assistance provided and effective organization.

CONCLUSIONS AND RECOMMENDATIONS

Single Entry Point is both a service delivery model for clients in need of continuing care and an alternative solution to nursing homes for the frail elderly. A close examination of the information collected during the evaluation raises some questions about the possibility of meeting the Single Entry point objectives, the amount of effort required to meet them, and the conditions to be established if this is to be achieved. It is in the context of these questions that the following conclusions and recommendations are presented.

GENERAL CONCLUSIONS

In addition to the objective of reducing premature institutionalization, the Single Entry Point included two client-focused goals. For seniors requesting service, it attempted to maintain the autonomy of the individual in their own home, while respecting their right to make their own decisions. The project also attempted to maintain or increase the seniors' capacity for self-care and the capacity of informal caregivers to care for the frail elderly in their charge.

While the pilot year was one where efforts were being made to refine the model as well as to test it, we do consider that the client-focused goals were reached quite adequately. On the basis of the results from the opinion surveys conducted among the frail elderly and the caregivers in their informal networks, we conclude that although the pilot regions used different procedures, client satisfaction was high in both regions. A large number of the frail elderly stated that the Single Entry Point was a positive or even very positive experience for them.

We maintain that, during the pilot project, the Single Entry Point model proved its ability to enable frail elderly persons with severe or very severe problems in several areas, to remain at home. Over an eleven-month period, an average per diem of $31 helped to keep 117 frail elderly at home for an average period of 8 or 9 months, depending on the cohort. At the end of the evaluation period, 91 were still living at home. Their needs were varied and all the service options proved to be useful in meeting these needs. Service development was and still is an ongoing activity in the pilot regions.

In view of the fact that according to many frail elderly, their ability to take care of themselves was different from one day to the next, it is difficult to assess the extent to which the second objective was achieved - maintaining or increasing capacity for self-care. Moreover, this objective applies as well to caregivers in the informal network.

A study of the 1991 service development plans for each pilot region revealed that the needs related to this objective were defined during the pilot project , and answers will be supplied this year.

The primary **organizational objective** of the Single Point Entry was to increase and improve the coordination in the delivery of the community services necessary for seniors to continue living at home. It attempted to present an accurate assessment of the needs to be met to enable seniors to continue living in the community and to define the types and quantities of the services required.

There are many indications that efforts made to reach this objective were productive. The most revealing perhaps is the fact that nursing homes, service agencies, and hospitals identified improved coordination, through the multidisciplinary team, as one of the Single Entry Point's strengths. The factors contributing to this success included multidisciplinary training meetings that focused on topics directly related to the Single Entry Point. Another was the resort to regional implementation committees composed of representatives of all Single Point Entry partners: nursing homes, service agencies, hospitals, senior citizen groups, etc. The committees sat regularly for the purpose of exchanging information, adapting services to the demand and taking part in the development of new services.

Furthermore, we believe that the multidisciplinary team, because of the measuring instrument used, succeeded in providing a very satisfactory assessment of the needs to be met in order to enable seniors to continue living in the community. As well, access to a more comprehensive assessment was indicated as one of the model's strengths by nursing homes, service agencies, and hospitals. The Assessment and Continuing Care Instrument form helped assessors to look at the whole situation. It encouraged a systematic approach to the assessment of needs and provided a common terminology which facilitated discussion. The service plan section prompted consideration of several options when selecting services appropriate for the needs identified. The profiles presented in Chapter II and Chapter II were based on information recorded on these forms, can support the conclusion that the multidisciplinary assessment makes it possible to more accurately determine the needs to be met.

From the organization's standpoint, the Single Entry Point project was also intended to demonstrate accountability and financial responsibility. Monitoring several items reflecting achievement of this objective was the responsibility of Departmental management. For example, two clinical audits were made in each pilot region during the trial period. As well, the cost analysis conducted during the evaluation revealed that the expenditure ceiling imposed for community support services was observed.

Single Entry Point also attempted to reduce the size of the nursing home waiting lists. We believe that the pilot project's achievement of this objective is undeniable. Shortening the waiting list began as of November 1989, following an evaluation of the cases on the list at the beginning of the project. Almost one out of every four persons listed received enriched services in each region. From the end of January to the end of September 1990, monthly nursing home waiting list was, on average, 6 times lower than during the same period of the previous year in the Fredericton region; and, on average, 4 times lower than for the same period of the previous year in the Péninsule acadienne region. The number of names on the waiting lists could have been further reduced and the number of available bed days reduced if beds had not been used for persons from other regions in the province. Such admissions accounted for 26.3% of those in the Fredericton region and 10.5% in the Péninsule acadienne region.

The results of the pilot project in relation to the objectives of Single Entry Point model are very positive. The list of improvements dealt with in the preceding chapter implies that there is room for improvement in the way the established objectives were met. Nevertheless, on the basis of all the information and opinions presented in the preceding pages, we can affirm explicitly that the Single Entry Point model is indeed capable of meeting the objectives assigned to it. In our opinion, the pilot project proved this to be so.

RECOMMENDATIONS

The following recommendations constitute, to some extent, an interpretation presented for the purpose of establishing internal consistency of the model for which a set of principles and goals was defined and a basic philosophy formulated. The recommendations are also based on observations we made in the course of the pilot project. Their source lies in our expertise in measurement and evaluation and in our understanding of the Single Entry Point stakes as well.

Structure - Single Entry Point is currently being implemented by two distinct organizations: Family and Community Social Services Division and the Extra-Mural Hospital. Achievement of the pilot project's objectives was the product of considerable cooperation between these units and the professionals who are part of the organizations.

The objectives of Single Entry Point and the model itself were agreed to by most of those who participated in the opinion survey. In our opinion, there were distinct advantages in having two agencies or divisions combine their expertise and direct the efforts to meet the objectives set. In fact, the present structure requires total, voluntary participation of each organization rather than participation by invitation only.

The problems identified in the evaluation were primarily operational in nature and affected the professionals on the multidisciplinary team. Although these problems were circumvented during the pilot project, there is no guarantee that this could continue indefinitely. This intensifies problems and indicates the need for change.

> Examples of problems identified: The principal members of the multidisciplinary team (social workers and health care workers) have their offices in separate buildings, which are sometimes far apart. There are differences in schedules: daily versus continuous schedules, which causes communication, and therefore coordination, problems. There are differences in the subdivision of the regional map, the effect of which is that one social worker has to be on a team with several health care workers. There are different legal requirements with regard to records keeping -- the Public Hospitals Act sets out requirements that the Single Point Entry will eventually have to meet.

The solution to some of these operational problems might not be the same for each region, considering their different backgrounds.

> **First Recommendation:** if a double structure is to be maintained, it is essential to make sure that the working environment is compatible for the principal members of the multidisciplinary team, the social workers and the health care professionals.

Multidisciplinary assessment - The multidisciplinary assessment was often mentioned as one of the Single Entry Point's strong points. The information provided at the end of the assessment and the expertise made available through multidisciplinary participation justifies the time and energy devoted to it.

The caregiver in the informal network is a key person in the Single Entry Point model. However, during the evaluation of the pilot project, in the section of the multidisciplinary assessment dealing with the capacity of informal caregivers to care for person(s) in their charge, assessors identified only information they considered relevant, and either recorded or did not record their assessment of the situation. Given that the multidisciplinary assessment instrument would standardize the collection of data with regard to the informal caregivers, it could be used to obtain structured information that might improve understanding of these key persons, their needs and the role they play for the frail elderly. Subsequently, the development of services for caregivers could be more easily oriented in terms of their real needs.

> **Second Recommendation:** after conducting the necessary research, prepare a list of the points to be identified during the multidisciplinary assessment concerning the informal caregiver, and develop an assessment scale that will enable assessors to express their opinions.

The assessment instrument developed for the pilot project is now more familiar to its principal users, who would like to have a guide for interpreting the results. We believe that such a guide would be helpful in analyzing the information collected, understanding the situation, and preparing recommendations. This would make it possible to extend the expertise of experienced people who might be asked to prepare the guide, to all users of the instrument.

> **Third Recommendation:** after conducting the necessary research, a guide should be prepared for the New Brunswick Assessment and Continuing Care Instrument which can be used to interpret the data collected.

Accessibility of services - The purpose of testing the Single Entry Point model was to try and find adequate service options that would offer a real alternative to institutionalization. After an analysis of the situation in each pilot region, we concluded that a large number of services would have to be instituted before the Single Entry Point is implemented, if they are not currently available. Furthermore, some services must be available at all times, either 24 hours a day or 7 days a week, or both. Homemaker services and emergency respite services belong to this category.

Our analysis of the duties assumed by homemakers indicated that for most (83%), personal care is part of their work. We also learned that some frail elderly need constant assistance: getting up, going to bed, sitting down, grooming, taking a bath. Others need constant supervision, day and night. The burden can be too heavy for an informal support network unless help is available at all times.

Fourth Recommendation: for where there is the demand, make services such as homemaker and emergency respite services accessible at all times, 24 hours a day and 7 days a week.

Implementation by other regions of the province - In the final analysis, many factors support the Single Entry Point as an appropriate model for New Brunswick:

- The Single Entry Point model is a long-term service delivery model that was developed on the basis of needs identified in the extensive study conducted in 1987 on long-term care services in New Brunswick.
- Results of the pilot project in relation to the goals of the Single Entry Point model are very positive, in light of both the client-focused goals or the organizational goals.
- The Single Entry Point model has proven its ability to enable frail elderly persons with severe or very severe problems to remain at home for an average per diem rate of $31 which is lower when compared to institutional rate.
- The goals of the Single Entry Point model met with widespread agreement on the part of clients, caregivers, nursing homes, service agencies, hospitals, associations and groups who were questioned during the evaluation of the pilot project.
- The Single Entry Point model is within the scope of "Health 2000", a comprehensive health strategy presented by the Government of New Brunswick.

Should it be decided to extend the Single Entry Point model to other regions of the province, the information gathered during the pilot project and through the evaluation will certainly prove useful.

Bureau de consultation ÉVAco enr.
April 1991

APPENDICES

APPENDIX A

DOCUMENTATION

Design

- Design for Pilot Project on Single Entry Point - March 1990.

Recording of Proceedings of the Provincial Advisory Committee

- Recording of Proceedings - July 12, 1989. Attachment 1 - Goals identified by Individual Advisory Committee Members and Cross-Referenced on the Basis of Meaning/Intent. Attachment 2 - Single Entry Point - Goals
- Recording of Proceedings - August 15, 1989.
- Recording of Proceedings - August 30, 1989.
- Recording of Proceedings - September 25, 1989.
- Recording of Proceedings - November 8, 1989. Appendix - Flaw of intake and assessment process
- Recording of Proceedings - January 31, 1990.

Recording of Proceedings of the Provincial Design Committee

- Recording of Proceedings - July 13, 1989. Attachment 1 - Goals identified by Individual Advisory Committee Members and Cross-Referenced on the Basis of Meaning/Intent. Attachment 2 - Single Entry Point - Goals. Attachment 3 - Report from each task group
- Summary of discussions - July 31, 1989. Attachment - Project Design
- Recording of Proceedings - September, 1989. Appendix A - Advisory Committee and Departmental Decisions Concerning Basic Design Components. September 1989

Documents prepared by the Provincial Design Committee

- Single Point of Entry Pilot Projects - Document # 1 - Corporate Plan. Draft: July 2, 1989.
- Goals. Draft: July 25, 1989.
- Determining Service Options. August 1989.
- First report: Subcommittee on Intake, Assessment and Crisis Intervention. August 13, 1989. Addendum. August 23, 1989.
- Report of the Task Group on Support to Caregivers. August 23, 1989.
- First report: Subcommittee on Targeting. August 25, 1989.
- Recommendations from Subcommittee on Case Management. August 28, 1989. Addendum - Framework. August 1989.
- Linkages in a Single Point of Entry. September 13, 1989.

Inter Office Memos and Letters

- Inter-Office Memo. Aline Saintonge. October 16, 1989.
- Inter-Office Memo. Aline Saintonge. October 18, 1989.
- Inter-Office Memo. Aline Saintonge. November 27, 1989.
- Letter to Participants - Single Entry Point Regional Meetings. Bernard Paulin and Ron Crawford. March 2, 1990.
- Letter to Single Entry Point Design Committee Member. Aline Saintonge. March 6, 1990.

Other Documents

- Towards a Continuum of Long Term Care Services. Presentation to the Minister prepared by the Planning and Evaluation Division. April 1987, revised November 1987.
- Minister of National Health and Welfare of Canada. Guidelines for Establishing Standards for Assessment and Placement for Adult Long-Term Care: A Single Entry Model. 1988.
- Address to the New Brunswick Association of Nursing Homes. Gérard Doucet. May 24, 1989.
- Report of the Commission on Selected Health Care Programs. McElvey-Lévesque Commission. July 1989.
- Recording of Proceedings from the Public Hearings. August 1989.
- Department of Health and Community Services - Briefing Note. August 2, 1989.
- Single Entry Point Demonstration Project: Description. January 1990.

Evaluation Progress Report

- Single Entry Point, Pilot Project, Evaluation Progress Report. Rita-Éva Lapointe. August 27, 1990.

APPENDIX B

KEY DOCUMENTS

List of documents

#1 Advisory Committee and Departmental Decisions Concerning Basic Design Components. September 1989.

#2 Recording of proceedings of the Design Committee.September 1989.

#3 First Report: Subcommittee on Targeting.August 25 1989.

#4 Recommendations from Subcommittee on Case Management Provincial Design Committee. August 28, 1989

#5 First Report: Subcommittee on Intake, Assessment and Crisis Intervention. Provincial Design Committee.August 13, 1989.

#6 Addendum. Subcommittee on Intake, Assessment and Crisis Intervention. Provincial Design Committee. August 23, 1989.

#7 Determining Service Options. Provincial Design Committee Task Group on Service Options. August, 1989.

#8 Report on the Task Group on Support to Caregivers Provincial Design Committee. August 23, 1989.

#9 Linkages in a Single Point of Entry. Provincial Design Committee. September 13, 1989.

#1 ADVISORY COMMITTEE AND DEPARTMENTAL DECISIONS CONCERNING BASIC DESIGN COMPONENTS. SEPTEMBER 1989.

TARGETING

Eligibility criteria for Access and Assessment component of SEP pilot project: accepted as defined in proposal with the request to define the "residency" criteria.

Eligibility criteria for enriched services: specifics to be determined when results of Pretest are available.

ASSESSMENT

1. Basic element of Intake and Assessment process is the multidisciplinary team: community nurse and social worker.

2. Functions of the assessment process:
   - to collect data
   - to define problems
   - to identify service needs
   - to identify remediable clinical, social, psychological problems
   - to identify personal/family/community support systems.

3. Assessment Process [See attached Model]
   Proposed model adopted with following modifications:
   - Since applicants for Special Care Homes are not required by the legislation to be assessed by the Department, they are to be informed of the total assessment process and what the system has to offer before the client decides on a residential option such as Special Care Home. Client may then choose:
     - the total assessment process [up to Panel] if he/she wishes to explore alternatives or
     - the multidisciplinary assessment if client has already decided on Special Care Home placement
   - Important to ask following question at Intake: What is the problem? Information received to be used to refer client to appropriate assessor [social worker or nurse] or to priorize assessments
   - Client approval to be requested for specialized assessment
   - Proposal that medical data sheet must be made available upon request pending provision of further services was not accepted. The medical report may be requested but provision of services not to be dependent on availability of document

4. Assessment Tool
   - Alberta Assessment Instrument [AAPI] with some modifications
   - Proposed Manitoba Medical Data Form to be examined more closely as it appears to be similar to the current NB Nursing Home Medical form and, therefore, a change may not be warranted
   - Supplementary assessment tools to be used when appropriate
   - Assessment Tool appears to be very extensive and detailed, especially for clients who come at the door with, for example, only one deficiency in the IADL's. There is a concern that seniors will not want to be subjected to such an extensive evaluation. Advisory Committee therefore recommends that professional discretion be used when administering questionnaire.

5. Panel
    - Panel to be comprised of three members: senior community nurse, senior community social worker, physician [with training in geriatrics when possible]. Back up for Panel members necessary to guarantee three members
    - Need to define criteria and procedures to guide panel in order to ensure consistency and objectivity
    - Decision making authority: the Panel may have decision making authority for case plans in the 50%-100% of the cost maximum category. The level of decision making authority to be delegated to the SEP Project Coordinator [who chairs the Panel] will be a regional decision. Therefore direct approval of the regional director may be required at some point.
    - Decisions to be unanimous or 2:3. Consensus desirable
    - Provisions in policy for client/caregiver's presence at Panel when appropriate
    - SEP Regional Coordinator to sit on Panel as professional [senior social worker or nurse] and to act as chairperson
    - Official minutes to be taken

6. Client Financial Participation
    - Proposal that services be totally subsidized not accepted as it would create a dual system [CBSS has a Client Participation Fee policy]
    - CBSS Participation Fee Policy to be applied to SEP

7. Cost maximum for community services [enriched services for clients at high risk of institutionalization]
    - Cost maximum set at 70% of Nursing Home cost to the province, that is $1470.00 per month [excluding client financial contribution]
    - Average maximum cost to be established by regions to operate within budget

8. Application of multidisciplinary model described in Addendum "Change in clinical situation" indicator to be added to list

9. Training of Assessors
    Proposal to send key individuals from each region in Alberta not supported due to cost factors. Suggestion that an Alberta trainer be brought in to participate in training session and that the possibility of bilingual trainers be explored

10 Correction by Fredericton Regional Director of data provided in Page 2 of Task Group proposal
    - Total of 11 social workers available for assessments
    - These workers have responsibilities for other adult client groups. Staffing would be equivalent to 5-6 staff-years

CASE MANAGEMENT

1. Model Time Lines
    - Time frame for Panel to review case should be 1 week
    - Estimated maximum time frame of 8 weeks to get on a Nursing Home Waiting List is too long. Current assessment process usually accomplishes this function within one week.
    - The suggested time lines are maximum time frames based on staffing resources available. However the intent is to accomplish the total assessment process in a shorter time frame whenever possible.
    - Decision was to test, monitor and readjust

2. Monitoring
    - Suggested monitoring standards were accepted for the at risk of institutionalization group with the following qualifications:
        - further exploration of monitoring activities that can be accomplished by service providers in the team
        - to test the schedule as is with built-in monitoring by service providers

3. Signing Authority and Budget Approval Process
   - Terminology: use Project Coordinator
   - Proposal accepted with following clarifications:
     - Service plans requiring between 50% and 100% of cost maximum may be approved by Project Coordinator [who chairs Panel] or may need approval by the Regional Director. Regional discretion should be allowed in this matter.
     - Service plans exceeding cost maximum should not exist as the cost maximum is an eligibility criteria. However if situation arises, other alternatives should be sought and final decision be at the Regional Director and Executive Director levels.

SERVICE OPTIONS

1. Service Menu
   Service menu approved with following modifications:
   - Rehab services [physiotherapy and occupational therapy] to be identified under a separate heading
   - Day Care services are not a Nursing Home service but a CBSS service that is purchased from different types of providers such as, nursing homes, the VON, community agencies, etc.
   - Geriatric Assessment services can be offered through day hospitals, the EMH, etc. and do not necessarily require established units in hospitals

2. Core Services
   Proposal to lodge responsibility of defining core services and to priorize service development at regional level accepted

3. Project Evaluation
   Project evaluation should address:
   a] assessment of needs [client needs] for community living
   b] assessment of service gaps

4. Expansion of Homemaker Role
   Concerns were raised regarding the expansion of the homemaker role. Implications for expanded role and potential expansion of role of homemaker [and other professionals] in SEP project to be treated as a separate issue.

5. Terminology
   "Skilled nursing services" in lieu of "Nursing procedures"

SUPPORT TO CAREGIVERS

1. Assessment of caregiver profile and support needs approved
2. Existing 24 hour response systems to be explored:
   - Community services line
   - EMH line
   - Life lines
3. Increased access to Homemaker Service
   - In terms of increased number of homemaker hours: possible within limits of budget and other service options available
   - In terms of accessibility to all suitable homemaker services: possible if agency meets Canadian Assistance Plan program criteria for federal reimbursement
4. Education programs for caregivers
   Should include hands-on tips to improve quality of life for client [and caregiver], ie. care of skin, aids and devices, etc.

LINKAGES AND COMMUNITY DEVELOPMENT

- Need for formal linkages at regional, departmental, and governmental levels recognized. In order to avoid duplication and creation of a larger number of committees, the following was suggested:
  - SEP structure [regional Implementation team, provincial Design and Advisory committees to be used for linking purposes
  - Intradepartmental and Interdepartmental committees on Services to Seniors under the Office of Seniors to be utilized for SEP linking purposes
- Proposal for formalized linkage process between two pilot areas accepted. Provincial project coordinator to facilitate this initiative
- Different types of linkages at regional level with service providers on continuum of care recognized

#2 RECORDING OF PROCEEDINGS OF THE DESIGN COMMITTEE.SEPTEMBER 1989

Chairperson: Aline Saintonge

Present:	Eric Gionet	Harry Bolan
	Ginette Beaulieu	Mildred Cook
	Carmen Godin	Yvon Thériault
	Rita Eva Lapointe	Dr. Murray Nixon
	Warren Davidson	Patricia MacNeil
	Lorraine Bourque	Claire Hine
Regrets:	Ed Pomeroy	Albini Leger
	Bernard Richard	

1. ISSUES IDENTIFIED AT AUGUST 23/89 MEETING AND UPDATE

- ACCESS TO NURSING HOMES BY DISABLED
  - Fredericton region has 4 disabled adults on the waiting list and the Acadian Peninsula has 6
  - Disabled adults requesting nursing home placement to be assessed with the SEP process
  - Placement of disabled adults in nursing homes not recommended - only when no other alternative
- LINKAGES WITH EMH
  - Discussions have been held with EMH. The following was agreed upon:
    - once assessment is completed by team, a referral will be made to EMH for hands-on nursing care.
    - EMH will keep family physician informed
    - EMH in agreement to use SEP assessment tool
    - operational linkages to be clarified
- LINKAGES WITH PUBLIC HEALTH
  - Clarification of PH role and linkages with EMH to be discussed with Departmental and EMH management
- RESOURCING
  - Resource needs for assessment, case management, and resource development presented to Advisory Committee. Advisory priorized the Assessment and Case Management functions for additional resources. Departmental management apprised of resource needs. Division now looking at alternatives.
- NURSING HOME CONCERNS RE IMPACT ON LEVEL OF CARE IN NURSING HOMES
  - Concerns communicated to Advisory and Department. Indication of willingness to address the issue when impact is demonstrated.

2. RESULTS OF ADVISORY COMMITTEE MEETING - AUGUST 23/89 - AND OF PRESENTATION TO DEPUTY MINISTER

- The following task group proposals were presented to the Advisory Committee:
  - Assessment
  - Case Management
  - Service Options
  - Support to Caregivers
  - Linkages
- A general presentation was made to the Deputy Minister and Departmental Management
- Appendix A reflects the decisions made at these meetings
- Comments/concerns/clarifications of Design Committee members
  - Doctor's approval not required in order to have EMH care. EMH informs doctor of proceedings.
  - Involvement of Medical Society in order for family physicians to obtain training in geriatrics would be recommended
  - Time frames identified in Case Management Task Group proposal may need to be revisited/revised after implementation
  - Acadian Peninsula does not wish to use the term "regional coordinator" because the individual has a supervisory role as well.

3. PROPOSAL OF TARGETING TASK GROUP

The following criteria was proposed, based on the results of the pretest:

Demographic/Cost
a. Must be 65 yrs. of age
b. Must live within designated demonstration areas, home, nursing home, hospital, special care home
c. Maximum cost for service plan to be established [$1470.00 per month to be ratified by Department]

Functional
a. Moderate risk in the ADL, or 2 moderate limitations in ADL
or
b. High risk in th IADL, or 3 high limitations in IADL
OR
c. Moderate risk in cognitive functioning
AND
d. 2 unmet needs in ADL, or IADL or fragile informal support system

Commitment
a. Must be willing to participate in the project
b. Must have primary caregiver willing to participate in the project

Concerns were voiced by members of the Design committee re the criterion related to the need to have a caregiver willing to participate in the project, as this would be discriminatory vis-à-vis seniors who do not have a caregiver.
This criterion was changed as follows: "Primary caregiver, where available, must be willing to participate in the project"

4. FUTURE AND ROLE OF DESIGN COMMITTEE

- The Corporate Plan had not identified a role for the Design committee after implementation. However since the design is not completed, the committee will be maintained for the next six months or until the major design tasks are completed ie. Goals/Objectives and Targeting.
- The committee will provide informed members to serve on Ad Hoc committees.
- The committee may be asked to revise design components presenting problems during implementation or to address major design issues not previously identified.

5. OUTSTANDING ISSUES / TASKS TO COMPLETE

- Revision of Assessment Tool: tool not completed. Final revision planned for November with printing thereafter.
- Training: discussions with Alberta for their trainors to do the initial training.
- Goals and Objectives Task Group to present proposal to Design Committee when product is completed.

#3 FIRST REPORT: SUB-COMMITTEE ON TARGETING DESIGN COMMITTEE TASK GROUPS AUGUST 1989.

COMMITTEE MEMBERS:

CARMEN GODIN, PRÉSIDENTE
DR. GERALD HICKEY
ALINE SAINTONGE

PROPOSED CRITERIA FOR ENRICHED SERVICES:

1. Premise: Major ojective of S/E + demonstration is to serve frail older persons at risk of Nursing Home placement. Thus necessary to establish program entrance requirements and procedures to ebsure the projet services those elders most in need.

2. Eligibility Criteria: Major limitations in functioning ability are presumed to be an important factor determining institutionalization and should serve as the major eligibility criterion for entrance to S/E +. The following criteria suggested:

2.2 Demographic

a. Must be 65 years of age
b. Must live within designated demonstrations areas, home, nursing home, hospital, special care home
c. Maximum cost for service plan

2.3 Functional

a. Moderate risk in the ADL, or 2 moderate limitations in ADL

OR

b. High risk in the IADL, or 3 high limitations in IADL

OR

c. Moderate risk in cognitive functioning

AND

d. 2 unmet needs in ADL, or IADL or fragile informal support system

2.4 Commitment

a. Must be willing to participate in the project
b. Primary caregiver, where available, willing to participate in the project

#4 RECOMMENDATIONS FROM SUB-COMMITTEE ON CASE MANAGEMENT PROVINCIAL DESIGN COMMITTEE. AUGUST 1989

1. That criteria be established for clear identification of what constitutes a crisis situation.

2. That once a crisis situation is identified that action be taken as soon as possible within the first 24 hours.

3. That once the crisis situation has stabilized completion of phase 1 of the comprehensive assessment be completed.

4. That a clear definition of the role of Case Manager\ coordinator be established which would include functions and responsibilities (please draw from information presented by Case Management Sub-Committee)

5. That all those involved in carrying out various functions of the Single Entry Point Pilot Project, receive thorough training in the concept and application of Case Management both at the system level and that of the individual Cas Manager\coordinator.

6. That two additional staff positions per Region (for a total of four persons) be hired. This would facilitate a successful completion of the project.

7. That the panel meet at a specified time weekly.

8. That a brief written up-date in relation to planned goals be completed on a monthly basis by individuals who suppl services to the client. These are to be given to the Case Manager\coordinator.

9. That a comprehensive report from each service provider be prepared quarterly in preparation for the planning team' quarterly review.

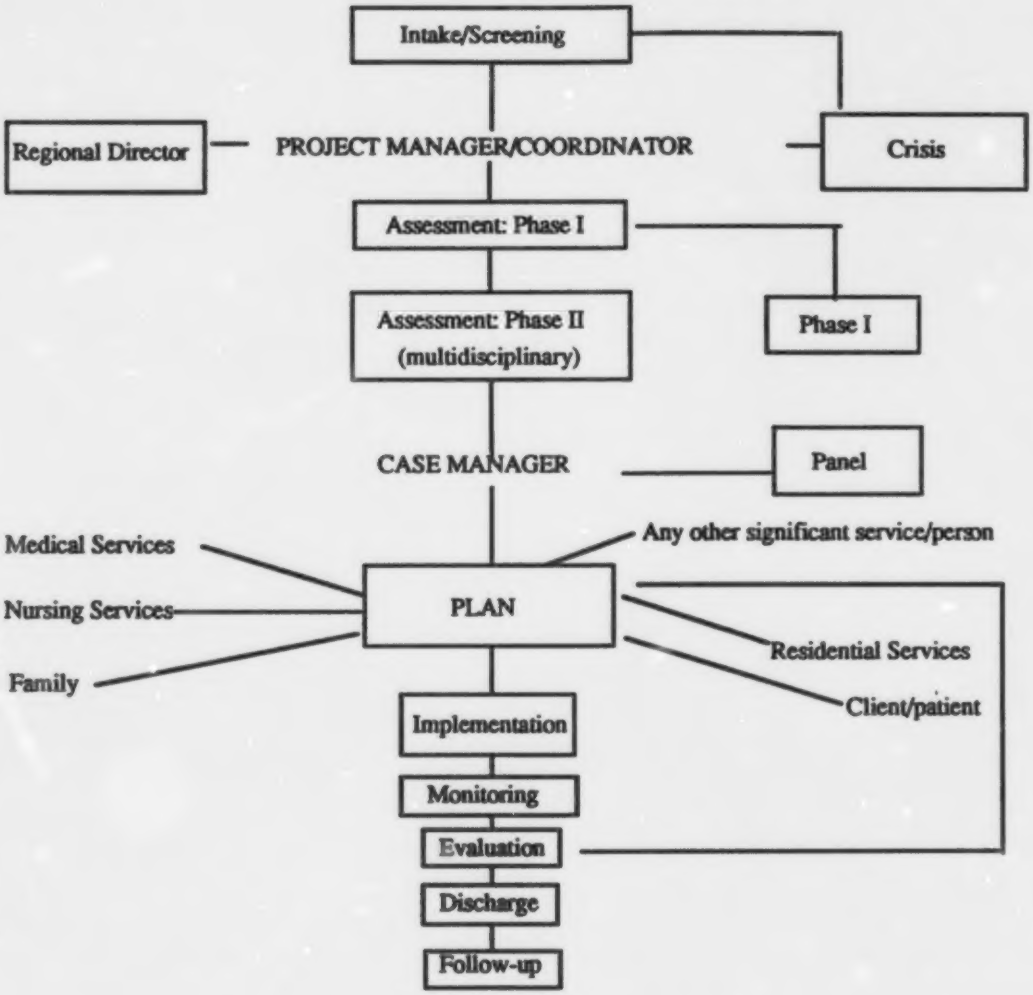
10. That a full planning team review on a quarterly basis.

11. That a Case Manager\coordinator make an in-home client contact at least twice in the first three months and thereafter at least once on a quarterly basis.

12. That weekly phone contacts with client be made in the first month and then as required thereafter.

13. That a clearly defined appeal process be designed indicating a direct line to the Regional Director.

SINGLE ENTRY POINT MODEL



SINGLE ENTRY POINT TIME LINES

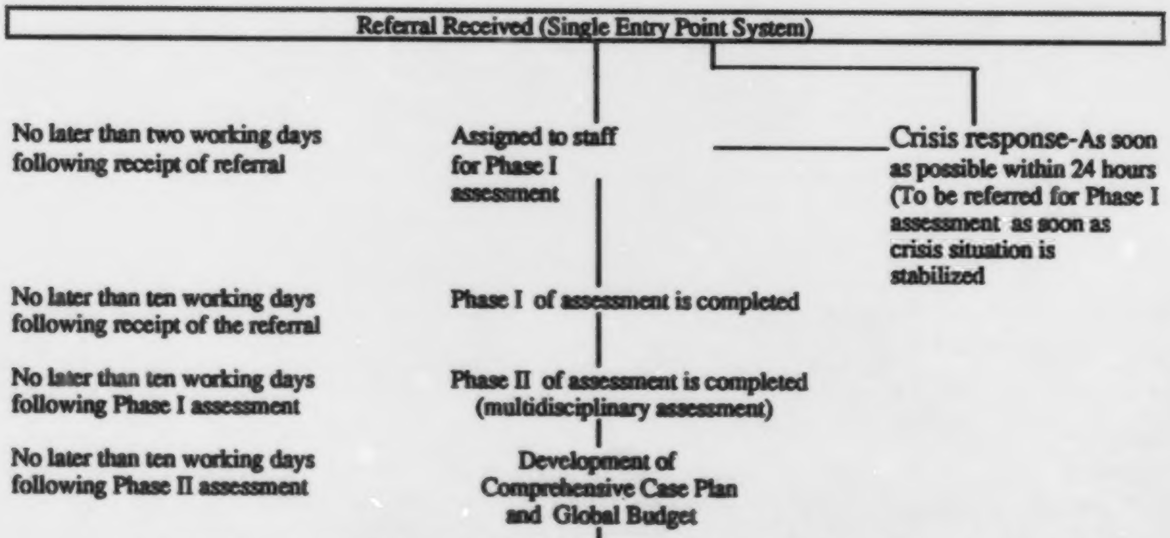
PLAN:

- To be develop with client/patient's individual team i.e. the individuals involved in supporting and or providing services to the individual; to include client if at all possible and/or most significant member(s) of his/her information support network.
- The budget supporting the individual plan is to be approved according to the process outlined in "Signing Authority for Financial Expenditures."
- As per minutes of Project Task Group Chairpersons' Meeting - July 31, 1989, the Panel:

MONITORING:

- The Case Manager/Coordinator will monitor all aspects of the plan implementation, effectiveness and clients satisfaction on an ongoing basis through formal and informal meetings with all those involved in providing support and service to the client. Specifically:

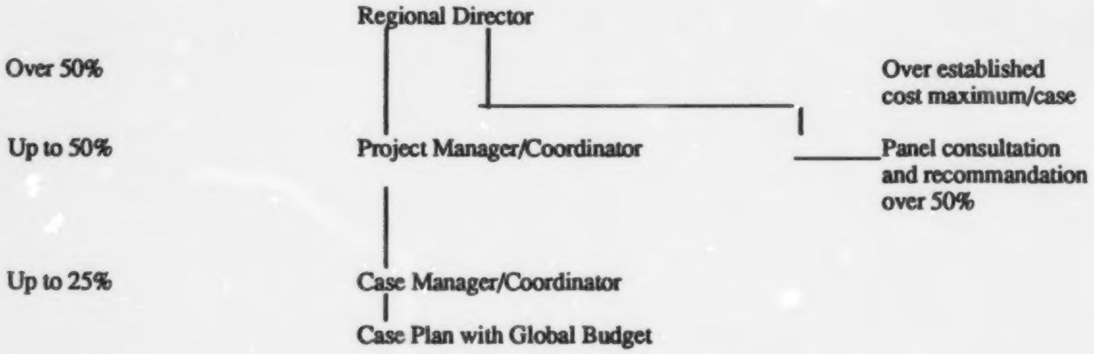
1. The Case Manager will visit the client in his/her home setting at least twice within the first three months and at least on a quarterly basis thereafter.
2. The Case Manager will contact the client or significant support person on a weekly basis for the first month and as necessary thereafter.
3. All those involved in providing services for the client will submit a monthly up-date report and quarterly comprehensive report to the Case Manager/Coordinator to ensure up-to-date information and accountability for the quarterly team review and planning session.
4. On a continuing basis, the Case Manager/Coordinator will carry out planning, implementation, monitoring and evaluation.


Referral Received (Single Entry Point System)
No later than two working days following receipt of referral
Assigned to staff for Phase I assessment
Crisis response-As soon as possible within 24 hours (To be referred for Phase I assessment as soon as crisis situation is stabilized
No later than ten working days following receipt of the referral
Phase I of assessment is completed
No later than ten working days following Phase I assessment
Phase II of assessment is completed (multidisciplinary assessment)
No later than ten working days following Phase II assessment
Development of Comprehensive Case Plan and Global Budget

The maximum time lapse between receipt of a referral to the completing of the Case Plan is not to exceed 30 workng days.

SINGLE ENTRY POINT PROGRAM

SIGNING AUTHORITY FOR FINANCIAL EXPENDITURES



All percentages are in relation to the established cost maximum per case. The cost maximum per case must be stated in terms of a maximum per diem or monthly expenditure so as to provide clear guidelines for the budget approval process.

BUDGET APPROVAL PROCESS - INDIVIDUAL CASE BASIS

1. Upon completion of the Case Plan, a global budget will be developed by the Case Coordinator which will state the projected total budget for the period covered (e.g. 6 months) as well as the project per diem.
2. If the proposed budget does not exceed 25% of the established cost maximum per case; the Case Coordinator will proceed to ensure the implementation of the plan.
3. If the proposed budget requires between 25 - 50% of the established cost maximum per case, the Case Coordinator will present the Case Plan and Case spending authorization. Project Coordinator is part of the line authority within FCSS and as such would have signing authority to an established level as designated by the Regional Director).
4. If the proposed budget requires over 50% but does not exceed 100% of the established cost maximum per case, the Case Coordinator will present the Case Plan and Case Global Budget to the Project Coordinator. If there are no acceptable alternatives which would contain the required dollar expenditures at or below 50% of the established cost maximum per case, the Project Coordinator will schedule a meeting with the SEP Panel at which the Case Coordinator will present the Case Plan and Budget Request. Based on this presentation, the Panel will make recommendations regarding the Plan and the allowable budget. The written recommendations will then be presented to the Program Coordinator who will then authorize the required budget. (In some regions, depending upon the authority designated to the Project Coordinator by the Regional Director, direct approval of the Regional Director may be required at some point within the 50% - 100% range of the established cost maximum per case).
5. If the proposed budget requires over 100% of the established cost maximum per case, the Case Coordinator will present the Case Plan and Case Global Budget to the Project Coordinator. If there are no acceptable alternatives which would contain the required dollar expenditures within the allowable cost maximum per case, the Project Coordinator will
    a) Forward the Case Plan and Budget request to the Regional Director,
    b) Schedule a meeting with the SEP Panel at which time the Case Coordinator will present the Case Plan and Budget request.

The SEP Panel must consult with the Regional Director prior to making its recommendations if those recommendations support an individual Case Budget which is in excess of the established cost maximum per case.

The Regional Director must provide authorization for budgets exceeding the established cost maximum per case.

GOALS AND OBJECTIVES FOR CASE MANAGEMENT SYSTEMS

- Basic Goal: Provide the best possible quality of service as efficiently and as cost-effectively as possible.

- Structural Elements of Case Management:
  1. Service Efficiency
  2. Service Effectiveness
  3. Cost-Effectiveness

Case Management:

. Programs need to have goals and objectives directed to all individual structural elements at both the direct service level for individual clients and the program level for the entire target population.

Goals: Individual Client Level (Micro Level)

For each goal, specific objectives must be stated in measurable terms e.g. in relation to client assessment, service planning, implementation, monitoring and evaluation.

The accountability goals at the client level relate to assuring that:
1. A client receives the services he/she needs.
2. That those services are provided in a timely fashion.
3. On a cost-effective basis.

System / Program Level (Macro Level)

A. Quality of Service

1. Encouraging a productive collaboration among agencies and programs that are part of the service network.
2. Building consensus within the network for definition of primary client needs and methods for solving or dealing with client's problems.
3. Structuring work to benefit staff as well as clients.
4. Building and maintaining a case management system that is stable enough to provide support for clients and dynamic enough to promote growth and change in organizations as well as in clients.

B. Accountability

1. Defining and implementing cost-effective services.
2. Developing adequate information and reporting procedures.
3. Establishing the appropriate technology to support management information and cost accounting systems.
4. Establishing a measurable system for management by objectives.

#5 INTAKE, ASSESSMENT AND CRISES INTERVENTION
AUGUST 1989.

COMMITTEE MEMBERS:

WARREN DAVIDSON, PRÉSIDENT
JOAN GAMBLE
MERIAM SIFTON
EUNICE MCELWAINE
GINETTE BEAULIEU
HILDA COMEAU
YVON THÉRIAULT
HARRY BOLAN

Preamble

1) The assessment process in these single entry projects must embrace the interdisciplinary approach in order to more accurately address the interrelated social, psychological and physical needs of the frail elderly and multiply handicapped.

Therefore, we must gradually abandon the previous and present approach of separate community based agencies under separate divisions within Health and Community Services, and establish a single line of responsibility towards a better coordinated and funded continuum of care.

This subcommittee unanimously agrees that the basic element of the S.E.P. and the intake and assessment process must be comprised of a team of community based social worker and community based nurse. That is, each case requiring comprehensive assessment must be seen and worked up by each member of the team respectively.

2) The assessment process is not only to collect data, to define problems and identify service needs but more importantly to identify remediable clinical, social and/or psychological problems and personal/family/community support systems.

3) For the purposes of these projects, this subcommittee is still not certain who the "target group" is. However, we agree that in most single entry systems, all frail elderly or multiply handicapped entering the "portal" requires a comprehensive interdisciplinary assessment.

Screening

Intake\Triage

1) Aside from the scope of these projects and the still uncertain "target group" initial contact with the single entry system may be made by the individual requiring services, or others known to the client. These requests for entry may come from the community or from within institutions.

2) Following "entry", the case is assigned to one member of the team (likely a social worker: 16 or 17 social workers versus one nurse in the Fredericton region) and then gathers:

    a) vital statistics and eligibility
    b) degree of urgency

and then proceeds to :

    a) provide information only
    b) refer to appropriate service - emergency/crises
    c) schedule routine assessment.

One member of the team will be known as the "case coordinator", depending on the "weight" of the case: i.e. social versus clinical.

Assessment Tool

1) The subcommittee unanimously agreed that the present tools used in New Brunswick, i.e. Nursing Home Eligibility and CBSS assessment, reflect a single disciplinary approach, and in the case of the former, is seriously flawed and are therefore inappropriate for the purpose of these projects and the S.E.P. system.

2) A careful review of the following instruments resulted in:

   a) Ebenezer Client Profile

      - lengthy
      - geared mainly for the institutionalized individual
      - NOT RECOMMENDED

   b) Manitoba Home Care Program: Care Assessment Form and Application/Assessment for Personal Care Home Placement

      - adequate assessment forms - but two part
      - recommend:

        1. select a more coordinated single form
        2. include the "panel" in our system as a means to

           a) enhance fail safe
           b) further multi-disciplinary consultation

3) O.A.R.S.

   - too lengthy - Not specific enough for our needs

   - NOT RECOMMENDED

4) Alberta Assessment and Placement Instrument for Long-Term Care

   - somewhat lengthy - but very comprehensive
   - reflects a true interdisciplinary approach with reassessment
   - emphasizes contributions of informal care system

Recommendations:

1) Adopt a modified A.A.P.I. for these projects.

2) Adopt the Manitoba Medical Data form; is unique in that it contains

   (1) request for geriatric consultation
   (2) compulsory statement as to why M.D. feels client requires personal care home placement

3) The same set of forms should be used for both projects.

4) A.A.P.I. must therefore be available in a translated form (french).

5) Modifications (See Reference Manual)

   a) P. 7 and 8 1B Financial Status
   b) replace Auxiliary Hospital with Extended Care Unit
   c) Appendix 1 - to reflect New Brunswick situation
   d) Appendix 2 - to reflect New Brunswick situation

6. The following supplementary assessment tools are recommended to be included by this committee as recommended by The National Advisory Council on Aging in (7) Geriatric Assessment: The Canadian Experience. (These recommendations were made (N.A.C.A>) in order to develop some continuity of assessment in all Canadian jurisdictions):

   A) Cognitive Impairment - Problems related to orientation, memory, attention and language:
   Folstein: Mini Mental State Test

   B) Depression:
   Yesavage: Geriatric Depression Scale (not the short form in Appendix IV)

   C) Suicide Risk: (as in Appendix V)

   D) Michigan Alcoholism Screening Test: (as in Appendix VI)

   E) Caregiver Burden: as in Assessment of stress on relatives of the elderly person (Isreal et al.) and (Hartman).

   F) Elder Abuse Assessment (Ross et al.)

   G) Include Appendixes VII and VIII as is.

Process

1) Individuals "entering" the system should have one or more deficiencies in basic A.D.L. and /or one or more deficiencies in instrumental A.D.L.
2) Services provided under the S.E.P. must be insured, especially for the purpose of the evaluation of the S.E.P. to remove bias.
3) Cost maximum for services in the home must equal cost of the institutional care minus O.A.P. (comfort allowance).
4) Case coordinator and teammate be given discretionary spending authority up to 1/4 of cost maximum. If cost estimate is equal to or more than 1/4 but less than 1/2 cost maximum, departmental supervisor must review. If cost is equal to or greater than 1/2 cost maximum, the case must be reviewed before panel.
5) The "panel" is available for consultation at any time during the assessment and/or follow up period.
6) All cases applying for institutional/residential care must be reviewed by panel.
7) The medical data sheet can be requested at any time during the assessment. Provision of this document by the family physician must be made available upon request pending provision of further services. The medical data must be available if a case is to come to panel.
8) Formal reassessments must be scheduled according to the acuity of the case and not be determined by workload. Case coordinators must not be overburdened with cases as is presently the case.

Staff Training

1) Workshops, seminars, etc., for the regional staff involved in both projects must be organized and begun as soon after the August workshop as possible.
2) Key individuals from each region should spend seven to ten days in Alberta for hands on experience with the assessment tool and consultation with departmental staff.

Crisis Intervention

1) Emergency services and consultation must be available twenty four hours per day, seven days a week. A coordinated call system must be developed with CBSS and EMH.
2) The most common intervention available today in most social crises is admission to an acute care hospital. Resources must be made available to have a corps of homemakers, sitter attendants available.
3) Crises can occur at intake, during the assessment and follow up period. Staff must be well trained with regard to available service options.

#6 ADDENDUM. SUBCOMMITTEE ON INTAKE, ASSESSMENT AND CRISIS INTERVENTION. PROVINCIAL DESIGN COMMITTEE. AUGUST 23, 1989.

Concerns raised:

(i) How can multidisciplinary assessment be provided to all clients entering the system?

Case coordinator has discretionary spending up to _ of the cost maximum. This also allows the worker to complete only his/her (Social Worker or Community Nurse) part of the assessment without calling in his/her partner to complete the multidisciplinary assessment.

Once the projected cost estimated is met or exceeded, the full assessment must be completed by the multidisciplinary team and the medical data sheet must be requested by the family/attending medical doctor.

Specific psychosocial and clinical indicators of risk will be provided in the assessment kit so that the case coordinator at his/her own discretion will call in for a completed assessment by his/her partner before the discretionary level.

eg:
- suspect abuse
- extreme poverty
- squalid housing
- incontinence
- mental confusion
- decreasing memory
- multiple medications
- falls

#7 DETERMINING SERVICE OPTIONS

DESIGN COMMITTEE TASK GROUPS AUGUST 1989.

COMMITTEE CHAIRPERSON: PATRICIA MACNEIL

COMMITTEE MEMBERS: Warren Davidson, M.D.
Carmen Godin
Lorraine Bourque
Léopold Pinet

Objectives

To develop services which will provide an alternative to unnecessary, premature or prolonged placement of persons in institutional care.

To develop services which will alleviate or relieve excess strain on caregivers or family members providing care.

To develop and involve community organizations and volunteers in the provision of specific home support services.

To develop and provide counselling and educational programs for the client, the family and a general awareness to the general public of the needs of the client.

The services as described in the following are meant to provide health care services, social services as well as community services to the client.

Service Options

The following list of Services Options and Resources are presented to meet the objectives as stated for the Single Entry Point System. Lengthy discussion of Committee and Design Committee led to the conclusion that a process to identify care services must be part of Regional Responsibility.

The following services are in order of priority:

Active Geriatric Assessment Units

1. These units focus on assessment, diagnosis and initial treatment of elderly persons.
2. These units may be located in existing hospitals.
3. Physicians interested in the aging population may be given basic training in assessment techniques, etc.
4. Geriatricians be recruited to large urban areas and used on a consulting basis to these units and physician. (Geriatric Assessment and Rehabilitation Second Report of the Health Care Committee on Health Care of the ELderly, Feb. 2, 1989).
5. These services may be offered as part of a day hospital concept.

Homemaker Services

1. To provide by trained personnel (Homemakers) personal care, and basic living needs to the client in their own home.
2. To provide home management services to client and the family in their own home.
3. To be an active member of the team, able to identify other needs eg. social to the team.
4. To teach the client to care for themselves (if possible) and be active in health promotion to the family as well as the client.

This service must be recognized and provision made to determine more attractive salary and benefits as well as the best methods of scheduling. A comprehensive job description should be provided. Provision must be made to provide regular educational programs.

Meals-on-Wheels

1. Delivery of nutritious hot meals to the client at their place of residence.
   Provide for utilization of hospitals , Nursing Homes and Restaurants in the area.
2. The volunteer component continue to be developed and organized to provide for this service.

Wheels-to-Meals

1. Transportation of the client to central location where they receive a nutritious meal and benefit from the social interaction. This would be a limited selective service depending on health status of client.
2. A well organized volunteer component again to be the dominant provider of this service.

Home Care Nursing Services

The Home Care Nursing Services be provided to assist the client to remain in their own homes in each region.

1. Skilled nursing procedures performed in the home to treat acute and chronic conditions, to assist in the convalescence of the client, or palliative care procedures.
2. Services for Home Care Nursing be provided by Public Health, V.O.N., Extra Mural Hospital - with special emphasis on long term care nursing skills.

Equipment and Supplies

1. The provision of special medical equipment to allow the client a better quality of life eg. assisted breathing apparatus or wheelchairs.
2. Some method be established to provide modified equipment for the client. This might entail contracting recognized local or provincial companies to provide this service.
3. Seniors Health Benefits Program - Review this program as to provide for cost sharing of eg. incontinence system.

Emergency Service

1. A mechanism for emergencies must be established, eg. the caregiver or spouse becomes ill, a method which would allow the client to be admitted to an institution until other arrangements can be made.
2. Establish methods which provide for a caregiver eg. sitter to go into the clients Home. This system would have to be activated in a very short period of time.
3. Establish "life line" services in the regions.
4. Continue to establish across the Province the 911 emergency.
5. Registry for demented individuals with Police and RCMP

Relief or Respite Service

1. Pre-scheduled type of services be available (social relief) in all regions.
2. Emergency - as outlined.
3. Regular intermittent re-admission service - this service allows for clinical monitoring of client in a hospital setting - also provides for social relief.
4. Day Care - Nursing Homes provide for day care where client on one or more days be transported to nursing home. The client will receive health supervision, meals and social support.
5. Adult Day Care - as provided in rural communities. The Care worker establish sessions in community halls, church halls, etc. where the client is provided with some form of activity, nutritional snack, some modified form of exercise as well as provide such services as blood pressure clinic, foot care, etc.
6. Sitter Services -

    1. This service to provide the caregiver with a select period of time away from the client. This service be provided in clients home.
    2. Service to be available as paid and augmented by volunteer component.
    3. Regions to support voluntary agencies and provide for educational programs.

Counselling Services

1. Programs be provided in the regions for the family and caregivers.
2. Programs be available to promote healthy aging and awareness.

Mental Health Services

Specialized mental health services be available to the client.

1. Use of psychiatric outreach mental health clinics to the client.
2. Involve the Mental Health Commission.
3. Alcohol and Drug Awareness Programs and support be made available to client.

Residential Services

1. Provide for more housing units for clients - presently inadequate in the province - provision to be made for emergency responses and social support structure within buildings.
2. Special Care Homes - an alternative to institutional care - standards must be enforced - these special care homes client should require minimum care and supervision and no nursing care. Strict admission criteria be established with ongoing assessment of client.
3. Granny Flats - mobile units provided near caregiver to allow monitoring by family.

   In Residential Services provision must be made for movement within the system. This movement can be defined by need and assessment eg. a client in a special care home to be assessed and determined if placement is needed in another Health Care institution eg. Nursing Home. Consideration must be given to the reverse of this movement.

4. Nursing Home Care - Nursing Home beds be determined by formula per capita - to establish equality in the regions.
5. Extended Care Units - be established to provide for the client beyond

Home Health Services

1. Nutritional Services - To client and family, education of the client and family in providing nutritious meals, modified diets and general counselling.
2. Home Therapy Programs - Clients be taught in the home environment to adapt to their surroundings. The services would include physiotherapy, occupational therapy, speech therapy.
3. Palliative Care - Services provided to dying client in their homes by existing services, extra mural, Hospice.
4. Pastoral Care - Involve church community to provide pastoral care to the client.

Community Education

Public Health play a significant role in providing education to the community. A preventative type of program at all levels of community.

Repair and Maintenance Service

Essential service for the senior in the system.

1. Volunteer Service - possibly established through volunteer agency in region - out of pocket expenses to volunteer be paid.
2. Assessment made as to type of work needed, eg. heavy cleaning - possibly a contract service.
3. Seasonal type of services be established eg. snow removal, grass cutting.

Transportation Services

1. Services be provided to allow client to attend to business matters in the Community eg. banking.
2. The degree of disability be considered to provide wheelchair vans, etc.
3. Transportation services, be contracted as well as a volunteer component.

The Essential Services as recommended be insured up to the maximum of institutional cost as established in long term care. No determination was made for cost of supplies.

A Single Entry Point system being a system to determine the needs of the client. Therefore, it must be client oriented, multidisciplinary providing for ongoing assessment as well as a sensitivity to the client needs. In establishing the Single Point Entry system there must be established a single clear line of responsibility for long term care in the Province of New Brunswick.

#8 REPORT OF THE TASK GROUP ON SUPPORT TO CAREGIVERS, AUGUST 1989.

COMMITTEE MEMBERS: **MURRAY NIXON, PRÉSIDENT**
YVON ARSENEAU
BERDIE DARRAH
SUE GATTO
CLAIRE HINE
HAL LOSIER
JUDY PAQUET
BEV WEEKS

Caregiving by the informal networks, i.e., from kin and friends, is the primary source of assistance for seniors in contemporary society.

Spouses, more than others, are likely to be providing care, and after the spouse and particularly when a spouse is no longer available, children primarily daughters who are themselves young elders or middle aged, are the most frequent caregivers for elderly Canadians. Friends are particularly important for companionship. There is generally one main helper or one person who provides most of the caregiving with evidence that female caregivers are taking on elder care without relinquishing any of their other duties.

The literature suggests that most caregivers make minimal use of formal supports and formal care is sought only after family resources have been exhausted.

Studies suggest that formal home care services do not replace or substitute for informal care. When formal services are provided, informal caregivers shift their energy from certain tasks to others, allowing them to continue or increase the provision of informal care. The relationship between informal and formal care services is not one of substitution but rather one of judicious utilization of formal services.

Caregiving can result in:

depression
psychological stress
lower satisfaction
decline in health
effects on leisure and family activities

Caregiver concerns include:

the relationship with the elder
the effect on health
the effect on leisure time
the elder person's future
the lack of information on formal support services

The Single Entry System must recognize the need for programs of support for caregivers and address these programs explicitly in its policy.

RECOMMENDATIONS:

Assessment

The initial comprehensive assessment must be a unit assessment, i.e. of the caregiver(s) as well as the client\patient.

The assessment instrument must identify the caregiver(s) current status, special characteristics, strain and support needs.

A complete caregiver profile is obtained, detailing specific caregiving activities, hours spent and informal and formal supports in place.

Identification of caregiver strain may be assisted by use of a caregiver strain questionnaire (example attached).

The case coordinator identifies the specific support needs of the caregiver and develops a caregiver plan. The needs identification and plan are done with the caregiver. Regular reassessments and revisions of the caregiver plan are performed.

Support

Caregivers commonly identify a need for information on existing support services and experience a problem in knowing where they can obtain the required information.

The case coordinator requires complete and current information on all educational activities and support agencies in the district.

Following the caregiver's needs assessment, the case coordinator is able to match the caregiver's needs to the appropriate supports (both educational and service) and coordinate their implementation.

A 24 hour response line, toll-free and well publicized, should be available for caregivers to call for required information on support services. The existing on call emergency social services line could be utilized.

Respite Care

Respite care has emerged as a top priority expressed by caregivers, yet is frequently begun far too late.

In most cases, in-home respite is preferable to respite care in institutions with its dislocation of the client\patient. The provision of in-home respite permits flexibility in the amount, timing and the services. Having the same worker return for in-home respite maintains continuity.

It is recognized that most respite is provided by informal caregivers. Families arrange for their own respite and frequently it is the secondary caregivers who come in to provide the primary caregiver with some time out. At times the respite care provided by family, friends and neighbors might be more coordinated.

Efforts must be directed towards the use of respite care services by caregivers of patients who have not yet reached the terminal phase of their illness as many potential caregiver users are unfamiliar with the concept and require education and encouragement to utilize it.

Respite care often offers more than simple respite, as caregiver support, education and assessment and\or therapeutic services may be provided to the client\patient, especially in out-of-home respite programs.

The respite program must be visible, concrete, tangible and useful. Caregiver education on the benefits of early respite care will be an important responsibility of the case coordinator.

Existing respite beds in nursing homes in each district should be maintained. well publicized and utilized for planned respite. Marketing is required for caregivers to use these beds appropriately for the client\patient.

The case coordinator should have the authority and capability to put emergency respite care, (primarily of a formal support nature) in place for up to 24 hours a day for a short period when the caregiver is suddenly incapacitated. Admission of the client\patient to an acute care institution should be avoided at this time unless there are specific medical indications.

Counselling

Counselling is provided by all the formal caregivers, beginning with assisting the caregiver in understanding the need for support services, through appropriate use of the formal caregivers, to planning for the future. When the need is identified, use should be made of established counselling services such as the Mental Health Clinics.

Volunteers

The informal caregiver network of friends and neighbors provides significant support to the primary caregiver. Friendly visits and telephone calls are very helpful. This informal network could be expanded in the program areas by adding volunteers from service clubs, senior citizen groups and the community itself to assist. Perhaps requested for volunteers could be made to appropriate groups. Some training would be required. Volunteers can help with handyman services and transportation.

Caution must be exercised ion requesting volunteer service of pensioners, as they may already be stretching their services to the limit.

Education Programs

Many education programs appropriate to caregivers are held in the community. The case coordinator must be aware of the best ones for the particular caregiver and incorporate them into the caregiver plan. Nursing homes may be an untapped resource for caregiver information programs. Programs such as "when Patients Grow Older" should be available for caregivers in the program districts and if this series is not planned for the Acadian Peninsula or Fredericton early this Fall, it should be arranged.

Homemaker Services

Adequate homemaker service is key to caregiver support. The homemaker service must be adequate in its quality and in the number of homemaker hours available. Uniform standards must be met.

The case coordinator should be able to access all suitable homemaker services in the area.

If existing services do not provide adequate numbers of homemakers, training programs should be held in both pilot areas, to train additional homemakers. A more long-term objective is to have these homemaker training courses offered by Community Colleges.

Current homemakers who would be involved in service to the elderly in the project, should receive in-service training on geriatric care.

Support Groups

Self-help groups and other non-profit organizations provide emotional support to caregivers. The case coordinator can assist the caregiver in identifying the appropriate groups.

The Family Physician

In many cases, the caregiver will have a family physician who knows him, and is caring for both him and the frail elderly\patient.. The knowledge and understanding of the family gained by the family physician and the bond developed between doctor and patient should be helpful to the case coordinator in developing and implementing the plan for the caregiver. Communication among caregiver, case coordinator and family physician is important. Often the physician's opinion is highly considered by th patient and family physicians need to be adequately informed regarding community support services, to enable them to provide proper information when consulted by their patients.

Resource Component

It is recommended that a health care professional, knowledgeable in community services, be employed by the project in each pilot area, to research and where necessary, facilitate the organization of community supports for the caregiver described in this report, to allow for ready accessing by the case coordinator and the caregiver. Estimated cost $50,000.

It is further recommended that funds be available to provide additional homemaker hours as deemed necessary, e.g., in enhanced respite services. Estimated cost for 20 additional homemaker hours per week for 40 clients for 6 months $200,000.

Finally, but certainly not of lesser importance, the task force on support to caregivers recognized that the care provided by informal caregivers needs to be acknowledged. Caregivers can easily lose their self-esteem and their work should be recognized whenever the opportunity presents itself. Very few frail elderly would be at home if they did not have dedicated caregivers.

CAREGIVER STRAIN QUESTIONNAIRE

YES=1 NO=0

Sleep is disturbed (e.g., because is in and out of bed or wanders around at night).

It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help).

It is a physical strain (e.g., because of lifting in and out of a chair, effort or concentration is required).

It is confining (e.g., helping restricts free time or cannot go visiting).

There have been family adjustments (e.g. because helping has disrupted routine; there has been no privacy).

There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation).

There have been other demands on my time (e.g., from other family members).

There have been emotional adjustments (e.g., because of severe arguments).

Some behaviour is upsetting (e.g., because of incontinence; has trouble remembering things; or accuses people of taking things).

It is upsetting to find has changed so much from his\her former self (e.g., he\she is a different person than he\she used to be).

There have been work adjustments (e.g., because of having to take time off).

It is a financial strain.

Feeling completely overwhelmed (e.g., because of worry about concerns about how you will manage).

TOTAL SCORE (COUNT YES RESPONSES)

Reference:
Robinson, B., Journal of Gerontology, "Validation of a Caregiver Strain Index", 1983, 38, 344-348.

#9 LINKAGES IN A SINGLE POINT OF ENTRY SEPTEMBER 1989.

A report prepared for the Single Entry Point Pilot Project Provincial Advisory Committee. Submitted by: Ed Pomeroy, Elvee Robichaud and Eric Gionet, committee chair.

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Introduction and Summary of Report
Functions of the Linkages Committee
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Continuum of Long Term Care (Fredericton/Penninsula)

Introduction/Summary of Report

The attached report is incomplete, in that, feedback gathered from the participants at the Provincial Workshop on August 21, 1989 has not yet all been fully incorporated into this copy. Therefore, it is important to note that corrections will be made to this report primarily in the section entitled, Continuum of Long Term Care for Fredericton and the Penninsula.

The Committee was concerned with establishing a continuum of care for both Pilot Regions to serve as a base line when identifying existing and needed resources. This base line can serve as a reference point when negotiating service agreements with community agencies or government departments. Service contracts are identified as an important tool for linking needed resources to the Single Entry Program. These resources may already exist in the community and, therefore, may need to be enhanced or the service may need to be totally developed. The continuum base line may help the Region to identify existing resources that could be approached to develop new services identified as needed by the Single Entry Program.

Within the attached report key sources are identified within the Department of Health and Community Services, within government departments and at the community(agency) level. Suggestions are made to allow the Regions to formulate committees at all three levels to act as consultants, problem solvers and disseminators of information.

The authors are also recommending that formalized linkages be set up and maintained between the two pilot regions at the field level. This linkage would allow for regular reviews of the process from a field perspective and ensure a level of understanding between regions, allow for joint problem solving and consistency in approach where possible.

The underlying task associated with the linkage committee is more than ensuring good communications at all levels and negotiating needed service agreements. However, good linkages at all levels will allow for broad participation, access to resources and clear understanding of functions and responsibilities.

The committee believes that linkages is another way of saying Community Development. Throughout the reports of the other committees numerous references are made to needed resources, the need to further develop certain services and to establish priorities within the Single Entry Program Regions. Community and resource development are the underlying task of the linkage committee. As identified within the report, some of the linkages may simply involve clarifying with service providers what role they want to play in the project. However, a higher level of involvement may include identifying needed resources and assisting in the creation of new services and/or service providers. Consequently, the Linkage committee has identified the need to establish a half-time community development position for the purposes of faciliating the anticipated growth of resources required for the Single Entry Program.

LINKAGE COMMITTEE

Functions

a) To identify key resources and service providers who constitute the continuum of care at the regional level.

b) To identify key responsibility centres within the Department of Health & Community Services.

c) To identify responsibility centres among key governmental departments.

d) To establish strategies to ensure a clear and updated and continuous flow of information to responsibility centers at all levels of involvement.

e) To establish formal and informal agreements with service providers at the regional level.

f) To establish mechanisms to allow for problem solving at all levels within the Department, Government, at the field level and between the pilot regions.

INTERDEPARTMENTAL DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Representatives from: Adult Protection Program
Medical Officer of Health
Alcoholic & Drug Commission
Mental Health Commission
Public Health Inspection
Hospital Services
Institution Services
Health Benefit Program
Office of Seniors
Research-Evaluation
Public Health Nursing

INTER GOVERNMENTAL
Representatives from: Dept. of Health & Community Services
N.B. Housing
Dept. of Income Assistance
Municipal Affairs
Human Rights
Ombudsman
Dept. of Recreation & Heritage
Dept. of Justice
Dept. of Advanced Education & Training

COMMUNITY LINKAGES (Suggestions)

- Use of regular CBSS advisory committee meetings. (Disseminating information/data collection).
- Meetings of the implementation team for problem solving sharing work and agreements on tasks, activities and responsibilities.
- The use of formalized agreements to ensure that all involved parties have an opportunity for input and understanding.
- Meetings of like service providers to ensure co-operation, fair and equal opportunity, consistency and agreement on procedures where possible.
- Meetings between representatives from the implementationteams of both regions to share information, problem solve and to ensure consistency in general goals.

COMMUNITY PARTICIPATION (Types:)

1. Entering a formalized agreement to provide specific services.
2. Agreeing to serve on the implementation team at the regional level.
3. Agreeing to receive update information by being part of a mailing list.
4. Agreeing to provide consultation on specific issues as the need arises.
5. Participating as a member of the Community Based Services for Seniors Advisory Committee.

LINKAGES - Interdepartmental/Intergovernment

Purpose

i) To serve as problem solvers and trouble shooters for pertinent issues that arise from the field operations.
ii) To receive, as a group, regular feedback on the progress of the project throughout its phases. To ensure clear flow of information.

Process

Recommend quarterly meetings facilitated by the Provincial Co-ordinator and Regional Coordinators.

SERVICE AGREEMENTS

Components

- Mission Statement
- Outline of what the Dept. agrees to do
- Outline of what the agency agrees to do
- Signatures

Some Specifics

- agreement on the primary responsibility center
- agreement on use of particular tools
- agreement on the conditions for sharing information and identifying information to be shared.
- agreement on specific time frames where necessary, ie: response to service request - routine/urgent
- agreement on procedures
- agreement on payment mechanisms
- agreement on evaluation procedures
- agreement on joint training activities (where appropriate)
- agreement on sharing resources

APPENDIX C

INTERVIEWS WITH THE ELDERLY AND THE INFORMAL CAREGIVERS

This appendix reports on the answers obtained during a series of interviews with the elderly and the informal caregivers who are part of the Single Entry Point program in each of the two pilot cohorts. It begins by describing the interviews themselves and goes on to present each of the questions asked, a compilation of the results, and a summary of the comments made, if applicable.

The interviews were conducted with elderly persons registered for enriched services under the Single Entry Point program and with the persons they designated as their informal caregivers. They were carried out in accordance with a protocol established on the basis of the questions presented in the following pages. In each pilot cohort, 25 seniors were chosen at random from the target group. Meetings were then scheduled with these persons and the person that each of them designated as his -her informal caregiver.

In the Fredericton cohort, where there are now 50 seniors registered for Single Entry Point enriched services, 22 elderly persons and 24 informal caregivers were interviewed. Three seniors were unable to participate in the interviewing to mental confusion. Another did not designate an informal caregiver. Among the 22 elderly persons, 10 were on the waiting list of the Senior Special Home Care at the beginning of the Single Entry Point project on November 1989.

In the Péninsule acadienne cohort, which currently has 41 seniors registered for Single Entry Point enriched services, 19 elderly persons and 25 informal caregivers answered the interview questions. Six seniors were unable to participate in the interviews because of mental confusion or a health problem that prevented them from expressing themselves. Among the 19 elderly persons, 4 were on the waiting list of the Senior Special Home Care at the beginning of the Single Entry Point project..

The questions dealt with the interviewees' knowledge of the project and their level of agreement with its objectives, as well with their experiences since November and their degree of satisfaction with these experiences. A compilation of the answers to these questions is presented below.

Four persons recruited on the recommendation of a gerontologist in each cohort were hired under contract and trained to conduct the interviews. The interviewers worked in teams of two and interviewed the elderly person and his-her informal caregiver at the same time but in separate rooms. In this way, the opinions of one could not influence the answers of the other. In a few cases, the caregiver did not live with the elderly person and was therefore interviewed at a different time.

Distribution of answers from the interviews with the elderly and the informal caregivers

	Elderly		Caregivers	
Question	Fred(n=22) %	Pén. acad. (n=19) %	Fred(n=24) %	Pén. acad. (n=25) %
1. Knowing about the information file				
Yes	50	79	71	80
No	50	21	29	20
2. If yes, what type of information is kept?				
My identification	32	63	--	--
My physical health	41	58	--	--
My social life	0	26	--	--
My preferences	9	37	--	--
My needs	23	47	--	--
My doctor	41	21	--	--
My mental health	14	26	--	--
My family	27	42	--	--
My natural caregiver	0	26	--	--
My physical environment	36	11	--	--
His or her identification	--	--	50	64
His or her physical health	--	--	63	0
His or her social life	--	--	25	32
His or her preferences	--	--	17	32
His or her needs	--	--	38	40
Information on myself	--	--	33	40
My preferences	--	--	17	32
My needs	--	--	8	32
3. Have heard of the following services:				
Meal service	86	79	75	84
Relief in home	41	58	46	72
Dietetics	27	47	25	36
Friendly visiting	27	63	25	52
Specialized equipment	91	79	83	88

By whom have you heard of each of the services mentioned?

In the Fredericton cohort, 53% of the seniors who said they had heard of a given service identified where they had heard of it. The services for which they were asked about their source of information were meal services, in-home relief, dietetics, friendly visiting, and specialized equipment. Study of the information sources that were mentioned 5 times or more reveals that the Red Cross and health workers (nurses, dietitians, occupational therapists, physiotherapists, and hospitals) were the most frequent sources (10 mentions each); in addition, "people, friends, and neighbours" were mentioned 6 times, and social workers, 5 times. In the Péninsule acadienne cohort, 69% of the seniors who said they had heard of a given service indicated their source of information. The results show that the Red Cross and immediate family were each mentioned 10 times as the source, nurses and hospitals together received 9 mentions, "people, friends, and neighbours" were mentioned 6 times, and social workers, 5 times.

The informal caregivers were asked the same question. In the Fredericton cohort, 88% of those who said they had heard of a given service indicated where they had heard of it. Study of the information sources that were mentioned 5 times or more shows that social workers and the Red Cross were the most frequent sources (13 and 12 mentions respectively), while "people, friends, and neighbours" were mentioned 9 times, and health workers, 6 times. In the Péninsule acadienne cohort, 86% of the informal caregivers who said they had heard of a given service identified the source of this information. The results reveal that social workers and the Red Cross were the most frequent sources (31 and 25 mentions respectively), followed by "people, friends, and neighbours" (7 times) and health workers (5 times).

Other services mentioned - Only 22% of the seniors interviewed indicated they knew of other services offered by the Single Entry Point project. Homemaker services were mentioned five times, and nursing services, twice. Live-in companions, ambulance transportation, other transportation, and life-line services were each mentioned once. As for the informal caregivers, 47% of the persons questioned were able to identify other services offered. Homemaker services were mentioned 12 times, and nursing services, 9 times. Heavy housecleaning services were mentioned 3 times and relief services, help with bathing, and financial assistance, 2 times each. Transportation, live-in companion, life line, counselling, housewatching, and snow removal services were each mentioned once.

Distribution of answers from the interviews with the elderly and the informal caregivers

Question	Elderly		Caregivers	
	Fred(n=22) %	Pén. acad. (n=19) %	Fred(n=24) %	Pén. acad. (n=25) %
4. Knows of other services	23	21	29	64
5. Agree with the approach (autonomy of the elderky)?				
Not at all	0	0	0	0
A little	5	0	17	4
Quite a bit	68	5	54	4
Completely	23	84	25	88
No opinion	5	11	4	4
6. Since becoming part of the program, do you think that you do . . . to take care of . . .?				
As much	41	58	50	64
Less	32	11	50	20
More	23	32	0	16
No opinion	5	0	.	
7. Has someone from the program taught you ways to take better care of yourself?				
Yes	27	37		
Has someone taught him or her ways to take better care of yourself?				
Yes			13	20

Comments - In the Fredericton cohort, 59% of seniors interviewed commented on whether their capacity to take care of themselves had changed since becoming part of the Single Entry Point project. Six of them mentioned a progression in the disease or disability affecting them. Four persons indicated they wished to get along by themselves with a little help of none at all. Two mentioned the help they received from their informal caregiver, and one indicated that the Single Entry Point does not offer enough services.

In the Péninsule acadienne cohort, 79% of the seniors questioned commented on their capacity to take care of themselves since becoming part of the program. Four mentioned that their disease or disability had progressed whereas three said their health had improved. Four said their spirits had been lifted or they felt reassured. Several (6) mentioned the help, advice, or visits they were receiving as a reason for taking better care of themselves.

The advice and teaching mentioned by the elderly had to do with movement - various techniques and exercises (7), meals (2), and personal care (1). The advice and teaching that the informal caregivers mentioned related to movement and transfer (3), dietetics, personal care (1), breathing (1), and orientation in time (1).

Question 8 - How satisfied are you with the services you are receiving?. The answers to this question revealed a very high degree of satisfaction in more than 97% of the cases. The answers related mainly to homemaker services, nursing care, relief care, meal services, and the specialized equipment service, services used by at least five of the seniors questioned. The informal caregivers were asked the same question. Their answers revealed also a very high degree of satisfaction in more than 97% of the cases.

Distribution of answers from the interviews with the elderly and the informal caregivers

Question	Elderly		Caregivers	
	Fred(n=22)	Pén. acad. (n=19)	Fred(n=24)	Pén. acad. (n=25)
	%	%	%	%
9. How have the services disturbed . . . life-style or habits?				
Not at all	77	84	96	76
A little	5	11	0	12
Quite a bit	5	5	0	8
A lot	14	0		
No opinion			4	4

Two main points emerge from 20 comments made by the informal caregivers regarding the impact on the Single Entry Point on lifestyles: the services make life easier for the persons concerned and also enhance the quality of life of the elderly.

Question	Elderly		Caregivers	
	Fred(n=22)	Pén. acad. (n=19)	Fred(n=24)	Pén. acad. (n=25)
	%	%	%	%
10. How much did you participated in deciding which services to received?				
Not at all	55	16	25	4
A little	27	16	38	8
Quite a bit	14	32	21	56
A lot	0	11	17	24
No opinion	5	26	0	8
11. How well do the services received meet the needs?				
Not at all	0	0	4	4
A little	9	0	8	4
Quite a bit	50	26	46	32
A lot	41	68	38	56
No opinion	0	5	4	4
12. Did you spend a lot of time to obtained the services?				
Not at all	77	53	67	52
A little	14	32	21	32
Quite a bit	0	0	4	8
A lot	0	0	4	8
No opinion	9	16	4	0
13. Are you glad you did it				
Not at all	9	0	4	4
A little	59	11	46	0
Quite a bit	18	79	42	88
No opinion	14	11	8	8
14. The program does not offer services that people could do themselves. Do you agree with this approach?				
Not at all	0	5	0	0
A little	0	0	8	4
Quite a bit	50	16	29	12
Tout à fait	41	63	54	76
No opinion	9	16	8	8

Distribution of answers from the interviews with the elderly and the informal caregivers

Question	Elderly Fred(n=22) %	Elderly Pén. acad. (n=19) %	Caregivers Fred(n=24) %	Caregivers Pén. acad. (n=25) %
15. What do you do to help the elderly? (Spontaneous answers from caregivers)				
Helping with personal care			29	24
Helping with dressing			4	16
Helping with transfers			4	12
Preparing meals			29	68
Doing housework			25	52
Running errands			29	36
Shopping			33	4
Doing repairs and yard work			13	0
Banking and managing budget			58	0
Being an escort			17	8
Helping with medications			8	16
Taking care of medical appointments			8	4
Watching over			4	32
Helping with social interactions			54	32
Giving moral support			4	4
16. How many hours per week do you spend helping . . . ?				
5 hours or less			38	0
6 to 15 hours			29	8
16 to 25 hours			8	8
26 to 35 hours			0	12
Nearly all time			13	28
24 hours/7 days per week			8	28
No answer			4	16
- Relationship of caregiver with the elderly				
Daughter			13	52
Son			21	20
Spouse			25	16
Relative			23	8
Friend			8	4
17. Did someone from the program teach you some ways to better take care of . . or to facilitate certain tasks				
Oui			0	16
18. Have you made known the services you prefer to receive, or have you expressed your opinion on types of services, on ways to dispense services, etc				
Never	59	0	71	4
Not often	14	5	21	8
Often	14	32	4	76
Frequently	5	11	0	0
No opinion	9	53	4	12
19. Do you think that your preferences and opinions were taken into account?				
Not at all	14	0	21	0
A little	18	0	21	12
Quite a bit	50	11	29	28
Completely	0	63	17	52
No opinion	18	26	13	8

Comments - In the Fredericton cohort, 8 of the 16 seniors who said they had never or not often made known the services they would prefer to receive or expressed their opinion on types of services, etc., gave reasons justifying this situation. Three of them indicated that someone else took care of that for them (spouse, daughter-in-law, niece). Three mentioned that the services were satisfactory the way they were and two other persons said they had not found it necessary to make comments. In the Péninsule acadienne cohort, the one senior who said he-she had seldom made known which services he-she preferred to receive indicated that someone else did all that for him-her.

As for the informal caregivers, 13 of the 17 persons in the Fredericton cohort who said they had never made known the services they preferred to receive or expressed their opinion on types of services, etc., gave reasons for this. Nine indicated that the services were satisfactory and they did not need to say anything; two said they had not had the opportunity to do so; one said he-she had never asked for help nor offered any assistance; finally, one thought the question was irrelevant because the senior he-she looked after was in a special care home. In the Péninsule acadienne cohort, the informal caregiver who said he-she had seldom made known his-her preferences indicated that he-she was not familiar with the existing services.

Questions 20 and 21. These two questions had a response rate of over 80%. If the interviewee ever had a problem or wanted to make a suggestion about the services, what would he or she do? Here are the options mentioned by the elderly and the informal caregivers interviewed:

Distribution of answers from the interviews with the elderly and the informal caregivers

Question	Elderly		Caregivers	
	Fred(n=22) %	Pén. acad. (n=19) %	Fred(n=24) %	Pén. acad. (n=25) %
Talk to family or friends	25	5	--	--
Talk to an SEP contact person	25	50	80	82
Talk directly to service provider	14	11	12	8
Talk to physician	7	--	--	--
Manage somewhat	9	--	--	--
Do not know	16	18	6	--
No answer	5	16	2	10
22. How necessary is this program in enabling you to stay at home?				
Not at all	0	5	0	8
A little	0	0	0	4
Quite a bit	32	11	38	8
Very much	45	79	46	72
No opinion	23	5	17	8
23. Do you wish to live for longtime yet at home?				
Yes	68	84	75	80
24. Generally speaking, how positive is your experience with this program?				
Not at all	0	5	0	4
A little	14	0	25	4
Quite a bit	68	16	46	12
Completely	14	74	29	72
No opinion	5	11	0	8

Comments -- No one element of the Single Entry Point program was singled out as having been positive or negative. The experiences varied. For the seniors interviewed, being able to get around by themselves again (mentioned 4 times), living at home (7 times), having company (6 times), and feeling secure (3 times) were all viewed as positive aspects. However, feeling embarrassed during personal care activities (2 times) and having had difficulty with family assistance in the beginning (8 times) were seen as negative aspects.

According to the caregivers, receiving assistance (mentioned 18 times) of good quality (4 times) and benefiting from a relief service (6 times) and rehabilitation equipment (3 times) were seen as positives. One positive aspect that was mentioned several times (15) was the feeling of security and peace of mind that resulted from the changes brought about by the Single Entry Point project. This means, for example, having someone with whom to share responsibility or discuss problems. Three persons said they appreciated the little bit of freedom this gave them.

The negative aspects mentioned concern specific difficulties encountered during the year: the long and difficult process (mentioned 3 times), lack of nursing support during a crisis (1 time), lack of consultation regarding change in homemaker (1 time), departure of relief care provider before the caregiver arrived (1 time), absence without notice (2 times). One person was concerned about the permanence of the project; another said that the care to be given took a great deal of time; two informal caregivers said they were often worried. Three persons mentioned the excessively long delay in obtaining reimbursement for sums paid for various services.

Other Comments - A few informal caregivers took advantage of the opportunity to make other comments. Each of the following elements was mentioned once: have access at home to the services of a psychologist; have access to a home exercise program; improve follow-up services; have access to services during the weekends. One person wondered why someone who devoted his-her time to caring for an elderly person in his-her family should not be paid. Two people worried about the impact of the very low wages paid to homemakers; another mentioned the importance of criteria for recruiting and hiring homemakers.

APPENDIX D

COMPILATION OF ANSWERS AND COMMENTS FROM THE PROFESSIONALS OF THE SINGLE ENTRY POINT PROJECT

This document presented the compilation of answers on the Questionnaire adressed to the professionals of the Single Entry Point Project. The comments received were reproduced and assembled for consultation. Each comment below is follow by the number of persons who made the same comment in each region.

All the professionals involved in the Single Entry Point project, 22 in the Fredericton region and 27 in the Péninsule acadienne region, completed the questionnaire designed for them. Each person was asked to indicate, using a four-point scale, the response that best represented his/her opinion. A weighted percentage was calculated in order to ensure equal weight was given to the opinion of social service and health service professionals.

Question 1: Indicate the degree of difficulty you presently encounter in each of the following steps in the Single Entry Point project.

DIFFICULTY PRESENTLY ENCOUNTERED		FRED (N=22) Weighted %	PÉN (N=27) Weighted %	Both Regions %
A. Evaluation of the client	Low difficulty	41	30	35
	Medium	45	32	39
	High	14	36	25
	Very high	0	0	0
	Cannot say	0	3	1
B. Planning of care	Low difficulty	23	30	26
	Medium	59	41	50
	High	18	24	21
	Very high	0	0	0
	Cannot say	0	5	3
C. Presentation to panel	Low difficulty	50	32	41
	Medium	36	41	39
	High	5	22	13
	Very high	0	0	0
	Cannot say	9	5	7
D. Implementation of plan	Low difficulty	18	34	26
	Medium	68	39	54
	High	14	17	15
	Very high	0	3	1
	Cannot say	0	5	3
	Not applicable	0	3	1
E. Monitoring of care plan	Low difficulty	9	32	20
	Medium	36	49	42
	High	32	12	22
	Very high	23	3	13
	Cannot say	0	3	1
	Not applicable	0	3	1

The study of the results show that the evaluation of clients represents a low difficulty for 35% of the professionals, the planning of care represents also a low difficulty for 26% and the presentation to panel represents a low difficulty for 41%. . None of the professional reported to have encountered high difficulty relating to the evaluation process. The implementation of the plan represents a low difficulty for 26% of the profesionals and a medium difficulty for 54% of them. Monitoring the care plan seems to be a more difficult task: this step was chosen by the largest number of professionals (13%) as representing a very high degree of difficulty. However, 20% of the professionals characterized it as a low-difficulty task.

Comments - Each comment reported below is followed by the indication of how many professionals of each region made it.

Assessment - Some comments about the steps relating to the assessment process referred to the lack of time available to do a satisfactory job (Fred.: 5 comments; Pén. acad.: 6). Some professionals stated that it was difficult to make a judgment since so many details were in the questionnaire (Fred.:1; Pén acad.:5). A few professionals noted in particular that it was often impossible to evaluate a client correctly on the basis of only one visit (Fred.: 4). There are some very complex cases and cases where it is difficult to choose between recommending placement in a special care home or placement in a nursing home (Pén. acad.: 2). Such borderline cases make the job more difficult. Also noted was a lack of information regarding the requirements or procedures for making a presentation to the panel and the effect this had on its degree of difficulty (Fred.: 2; Pén. acad.: 7).

Service plan implementation - The comments reflect the difficulty of finding services appropriate to the situation (Fred.: 5 comments; Pén. acad.: 5) and the difficulty of finding someone (service provider) able to help out for a great number of hours on a regular basis, daily or weekly (Fred.: 2; Pén. acad.: 2).

Monitoring the care plan - The comments show that its difficulty, if not impossibility, relates to an excessive workload, resulting in a lack of time to devote to monitoring (Fred.: 7; Pén. acad.: 1), and the obligation to meet other priorities (Fred.: 4; Pén. acad.: 4). The only thing that can be done is to ask the clients to call if a problem arises (Fred.: 2).

Question 2: Name two aspects of the Single Entry Point project that most interested or helped you.

The multidisciplinary approach was mentioned frequently as an interesting aspect of the Single Entry Point: such an approach makes it possible to learn, understand, obtain a broader view of a situation, define common expectations (Fred.: 18 comments; Pén. acad.: 16). Study of the comments reveals that many professionals greatly appreciated being able to offer the frail elderly a viable alternative to the nursing home (Fred.: 7; Pén. acad.: 4).

Question 3: What impact does the Single Entry Point project presently have on your job?

A great increase in the volume of work (Fred.: 19 comments; Pén. acad.: 20), a backlog impossible to make up (Fred.: 2; Pén. acad.: 1), a shift of priorities (Fred.: 9; Pén. acad.: 6), and a lack of human resources (Fred.: 7; Pén. acad.: 6) are all elements of the pilot project's main impact stated by 72% of the professionals..

Question 4: Are there activities in your job that you would consider particularly related to the case management approach? Which ones (list two if possible)?

The professionals considered very diverse activities to be related to the case management approach: participating in a case conference, monitoring the service plan, coordinating services, managing for the client (providing education and advice), counselling, recommending, etc. From the standpoint of the professionals, this approach does not seem to be specific to the Single Entry Point Project. Fifty percent (50%) of the professionals did not answer this question.

Question 5: Client evaluation (instrument and process) is a major step of the Single Entry Point project. Mark an "x" at the point that indicates your degree of satisfaction with the possibility of identifying the actual needs of the elderly person through this evaluation.

	FRED (N=22) Weighted %	PÉN (N=27) Weighted %	Both Regions %
Poor	9	0	5
Notable	50	24	37
Large	32	56	44
Very large	9	14	12
Cannot say	0	5	3

Question 6: The client evaluation instrument includes much information. Mark an "x" at the point that indicates, in your opinion, the percentage of this information that is useful in identifying the needs of the elderly person and in preparing a service plan that is truly adequate within the framework of the Single Entry Point project.

Less than 40%	5	14	9
40 to 59%	32	19	26
60 to 79%	41	17	29
More than 80%	23	44	34
Cannot say	0	5	3

Question 7: In your opinion, how much do the results of this evaluation (quantity and quality of the information obtained, etc.) justify the time and energy required to fill out the evaluation?

Not at all	9	0	5
A little	41	36	38
Rather well	45	40	43
Perfectly	0	15	7
Cannot say	5	10	7

Question 8: Mark an "x" at the point that indicates, in your opinion, the quality of the coordination between the people offering services to the elderly person registered in the Single Entry Point project.

Very poor	0	14	7
Poor	45	27	36
Good	27	34	31
Very good	18	13	15
Cannot say	9	13	11

Most of the comments refer to coordination of the work as a multidisciplinary team. At this stage of the project, each professional knows more about what the other professionals do (Fred.: 1 comment; Pén. acad.: 3). Evaluation of the client and planning of care were viewed as the principal mechanisms of coordination (Fred.: 2). A great desire to carry out these tasks was noted, combined with a great difficulty in doing so (Fred.: 6; Pén. acad.: 11). The main difficulties mentioned were the work schedule of the Extra-Mural Hospital (Fred.: 6; Pén. acad.: 14), the other responsibilities of these professionals, notably the responsibility for acute care patients (Fred.: 3; Pén. acad.: 3), and in the Fredericton region, the fact that the offices are far apart (Fred.: 3). The good of the client is a common concern (Pén. acad.: 1).

Question 9: Mark an "x" at the point that indicates, in your opinion, the degree of improvement in this coordination of the people offering services to the frail elderly person.

None	14	0	7
Small	32	29	30
Notable	45	34	40
Very large	5	24	14
Cannot say	5	13	9

Question 10: Mark an "x" at the point that indicates how much you have felt a part of a multidisciplinary team.

	FRED (N=22) Weighted %	PÉN (N=27) Weighted %	Both Regions %
Not at all	5	14	9
Somewhat	14	26	20
Adequat	73	34	54
Very much	9	20	15
Cannot say	0	5	3

Question 11: Mark an "x" at the point that indicates, in your opinion, the degree of effectiveness with the present system of sharing responsibilities among the members of the Single Entry Point multidisciplinary team.

Not at all	0	21	11
Somewhat	18	19	19
Adequat	73	35	54
Very much	9	10	10
Cannot say	0	15	7

Study of the comments makes it possible to identify two suggestions for the Fredericton region: that the responsibility for the deadlines be shared better (Fred.: 2 comments) and that the exchange of information between professionals be facilitated or accelerated in various ways (Fred.: 5). The comments made by the Péninsule acadienne professionals indicate an improvement has occurred in this regard, but the responsibility for taking the initiative is too often left to the social workers (Pén. acad. 5). One professional suggests that the health workers could be responsible for clients applying for nursing home admission (Pén. acad.: 1).

Question 12: Mark an "x" at the point that indicates, in your opinion, the degree of improvement in the linkages between the hospital discharge planning team and the Single Entry Point multidisciplinary team since the beginning of the project.

None	23	3	13
Small	9	0	5
Notable	27	50	39
Very large	0	3	1
Cannot say	41	45	43

Question 13: In your opinion, what percentage of clients registered in the Single Entry Point project have learned new ways to better care for themselves since the beginning of the project?

25% or less	36	0	18
26 to 50%	18	34	26
51 to 75%	5	15	10
More than 75%	5	5	5
Cannot say	36	46	41

Question 14: In your opinion, what percentage of informal caregivers offering services to the frail elderly person in the Single Entry Point project have learned new ways to better assume their caregiving role since the beginning of the project?

25% or less	23	0	11
26 to 50%	23	12	17
51 to 75%	18	18	18
More than 75%	5	17	11
Cannot say	32	54	43

Question 15: In your opinion, what percentage of the people registered in the Single Entry Point project were able to participate in decisions concerning them?

		FRED (N=22) Weighted %	PÉN (N=27) Weighted %	Both Regions %
Percentage of clients				
	25% or less	0	8	4
	26 to 50%	5	19	12
	51 to 75%	32	13	22
	More than 75%	50	34	42
	Cannot say	14	27	20
Percentage of informal caregivers				
	25% or less	5	3	4
	26 to 50%	0	10	5
	51 to 75%	32	20	26
	More than 75%	50	48	49
	Cannot say	14	20	17

Question 16: Describe the reaction of the majority of clients and their informal caregivers to the multi-disciplinary evaluation process by indicating their degree of concern, annoyance and satisfaction, using the following scale.

CLIENTS				
Degree of concern	No reaction	0	0	0
	Small	23	24	24
	Notable	23	27	25
	Large	0	29	14
	Cannot say	55	20	37
Degree of annoyance	No reaction	0	10	5
	Small	41	41	41
	Notable	5	26	15
	Large	0	0	0
	Cannot say	55	23	39
Degree of satisfaction	No reaction	0	0	0
	Small	5	0	2
	Notable	55	63	59
	Large	18	20	19
	Cannot say	23	18	20
INFORMAL CAREGIVERS				
Degree of concern	No reaction	9	10	10
	Small	18	26	22
	Notable	18	34	26
	Large	0	7	4
	Cannot say	55	23	39
Degree of annoyance	No reaction	5	10	7
	Small	36	27	32
	Notable	5	26	15
	Large	0	14	7
	Cannot say	55	23	39
Degree of satisfaction	No reaction	0	0	0
	Small	5	0	2
	Notable	50	65	58
	Large	23	18	20
	Cannot say	23	18	20

The high percentage of the answers "cannot say" for the degree of concern and the degree of annoyance came from the nurses in the Fredericton region (near 75%) and in the Péninsule acadienne region (near 50%) who feeled to have no concern for these questions. As far as the social workers, 36% did not give an answer in the Fredericton region while all the social workers in the Péninsule acadienne region did give an answer.

Question 17: Mark an "x" at the point that indicates, in your opinion, the degree of impact that the Single Entry Point project has had on the demand for community services.(Social services and Health Services).

	FRED (N=22) Weighted %	PÉN (N=27) Weighted %	Both Regions %
None	0	0	0
Little	9	3	6
Notable	32	34	33
Very large	55	54	54
Cannot say	5	10	7

Question 18: Did the Single Entry Point project have unexpected effects? Specify.

Several professionals mentioned a new awareness of one kind or another: seeing and understanding that old age is not a disease (Fred.:1 comment), finding that, in general, seniors wish to be helped above all to maintain their independence (Fred.: 2), seeing that staying in the community is a real option for seniors with assistance (Pén. acad.: 2). One comment was made about the augmentation of the number of clients for the Special Home Care (Pén. acad.:1) and about a possible financial contribution by the family's members (Pén. acad.:1). Another comment was made concerning a lack of preparation for the increase demand of services (Fred.:1). One unexpected effect that was mentioned many times is that of the continuing growth of the workload (Fred.: 6; Pén. acad.: 3). Lastly, it was pointed out that the Single Entry Point Project had been given emphasis and priority at the expense of the clients of other programs (Fred.: 2; Pén. acad.: 1).

Question 19: In your opinion, is the Single Entry Point project a strategy or an approach by which the needs of frail elderly people can really be met?

Hardly	0	0	0
Slightly	32	3	17
Adequatly	64	46	55
Perfectly	5	49	27
Cannot say	0	3	1

The comments indicate that most of the professionals believe the various types of resources need to be increased in order to ensure that the needs are really met (Fred.: 6; Pén. acad.: 7).

Question 20: How does the Single Entry Point project meet your professional expectations?

The feelings of the professionals involved in the Single Entry Point project can be summed up quite clearly in the form of one of the comments made: worthwhile but unsatisfactory.

Indeed, all the elements of the Single Entry Point combine to make it a worthwhile project on the professional level (Fred.: 13 comments; Pén. acad.: 18). What made it unsatisfactory at the outset was the respondents' impression that their comments had not been taken into account (Fred.: 1). What made it unsatisfactory throughout the year was, above all, the conditions in which it was implemented: failure to develop community resources before the project was launched (Fred.:2), failure to appreciate the current workloads (Fred.: 10; Pén. acad.: 4), lack of time to perform the duties adequately, notably evaluation, despite a tool with such great potential (Fred.: 1; Pén. acad.: 1), constant lack of resources (Fred.: 4; Pén. acad.: 2).

APPENDIX E

COMPILATION OF ANSWERS TO THE QUESTIONNAIRE FOR INSTITUTIONS AND AGENCIES CLOSELY PARTICIPATING IN THE SINGLE ENTRY POINT PROJECT

In December 1990, a questionnaire was sent to the persons in charge of the institutions and agencies closely participating in the pilot project for the purpose of obtaining their opinions on the Single Entry Point Project and finding out what kind of impact it has had on their institutions and agencies.

The response rate to the questionnaire was high. Of the 16 nursing homes, 14 returned the questionnaire, representing a participation rate of 87.5%; 16 of the 20 service providers answered, representing 87.5%; and 8 of the 10 hospitals contacted took part in the survey, representing a participation rate of 80%.

FIRST PART - The Single Entry Point Project has several objectives relating to the frail elderly clientele, people at risk of loosing their independence. We would like to know your opinion on the following objectives:

1. The Single Point Entry Project seeks to maintain the independence of the frail elderly living at home by offering them the needed services through community social services and the Extra-Mural Hospital.

Degree of agreement	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Hardly agree	1	7	1	6	0	0	4
Agree	5	36	3	19	0	0	18
Largely agree	0	0	5	31	2	25	19
Greatly agree	5	36	7	44	6	75	51
Can not say	3	21	0	0	0	0	7

2. The Single Point Entry Project seeks to maintain the independence of the frail elderly by maintaining or increasing their capacity to care for themselves so they may continue to live as long as possible in their home environment.

Degree of agreement	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Hardly agree	2	14	1	6	0	0	7
Agree	3	21	4	25	0	0	15
Largely agree	0	0	5	31	1	13	15
Greatly agree	6	43	6	38	7	88	56
Can not say	3	21	0	0	0	0	7

3. When a frail elderly person has someone in his or her surroundings that cares for him or her, the Single Point Entry seeks to maintain or increase the capacity of this informal caregiver so the frail elderly person can continue to live as long as possible in his or her home environment.

Degree of agreement	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Hardly agree	2	14	2	13	0	0	9
Agree	4	29	4	25	0	0	18
Largely agree	2	14	6	38	2	25	26
Greatly agree	3	21	4	25	6	75	40
Can not say	3	21	0	0	0	0	7

4. The Single Point Entry Project seeks to involve the elderly person or the informal caregiver whose lives are affected by a decision in the process of arriving at that decision.

Degree of agreement	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Hardly agree	2	14	1	6	0	0	7
Agree	3	21	4	25	0	0	15
Largely agree	1	7	5	31	3	38	25
Greatly agree	5	36	6	38	5	63	45
Can not say	3	21	0	0	0	0	7

5. The Single Entry Point Project seeks to allow the elderly to consider Nursing Homes (Institutional environment) only after all community options have been considered.

Degree of agreement	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Hardly agree	2	14	2	13	0	0	9
Agree	2	14	2	13	0	0	9
Largely agree	1	7	6	38	3	38	27
Greatly agree	8	57	5	31	5	63	50
Can not say	1	7	1	6	0	0	4

Comments on Single Entry Point Project Objectives - No matter what the objective discussed, emphasis was always placed on the need not to use pressure, but to make quite sure of what the wishes and abilities of the persons involved are, whether they are the frail elderly or the caregivers. A total of 14 made this kind of comment. Mention was also made of the need to offer 24-hour service (1 comment), provide the appropriate level of service (4 comments), do more, even much more, for caregivers (5 comments), assess carefully their capacity to assume the task required (5 comments), and to utilize realistic options (3 comments).

SECOND PART - The objective and procedures of the Single Entry Point Project have already made some impacts. We wish to know the changes that have occurred as a result of the Single Entry Point Project and the degree of change involved.

6. Has the Single Entry Point Project had an impact on your institution or agency?

Impact	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Yes	13	93	16	100	7	88	93
No	1	7	0	0	1	13	7

7. Your opinion on the degree of impact that the Single Entry Point Project has had on your institution or agency.

Degree of impact	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Small impact	2	14	6	38	0	0	17
Medium	3	21	5	31	1	13	22
Large	3	21	3	19	5	63	34
Very large	5	36	2	13	1	13	20
Can not say	1	7	0	0	1	13	7

Questions 8 and 9 dealt with the kind of impact. The analysis are presented in chapter VII.

10. As a result of the Single Entry Point Project, each region would have to enhance or develop a group of community services such as homemaker services, in-home relief services, meal services and friendly visiting services, physiotherapy, ergotherapy, etc. to meet the needs of the frail elderly.

Degree of impact	Nursing Home		Service Provider		Hospital		Total Weighed %
	N=14	%	N=16	%	N=8	%	
Small impact	1	7	1	6	0	0	4
Medium	2	14	2	13	0	0	9
Large	3	21	3	19	2	25	22
Very large	4	29	8	50	6	75	51
Can not say	4	29	2	13	0	0	14

Comments - Services are the basis of the Single Entry Point Project's success (2 comments). Services should be available everywhere without exception (2 comments). At the moment, the needs are greater than the services available (2 comments). The hospital is still used from time to time for intermittent relief (1 comment).

11. As a result of the Single Entry Point Project, the staff of institutions or agencies involved with the frail elderly will have to reassess their personal attitudes and their professional approach based on this clientele.

Degree of impact	Nursing Home		Service Provider		Hospital		Total Weighted %
	N=14	%	N=16	%	N=8	%	
Small impact	0	0	3	19	1	13	10
Medium	1	7	2	13	0	0	7
Large	3	21	2	13	2	25	20
Very large	7	50	6	36	4	50	46
Can not say	3	21	3	19	1	13	18

Comments - Several mentioned that their attitudes and approaches had become adapted to the elderly with whom they had been working for a long time (5 comments).

12. As a result of the Single Entry Point Project, the population in general and the senior citizen in particular will have to understand the importance of accepting personal responsibility for health.

Degree of impact	Nursing Home		Service Provider		Hospital		Total Weighted %
	N=14	%	N=16	%	N=8	%	
Small impact	1	7	2	13	1	13	11
Medium	2	14	4	25	1	13	17
Large	3	21	4	25	0	0	15
Very large	6	43	3	19	6	75	46
Can not say	2	14	3	19	0	0	11

Comments: - It is important to be realistic in this regard (2 comments). Accepting personal responsibility for one's health and well-being is a question of physical and mental ability rather than one of force (1 comment). This is already happening, proof of which is the number of frail elderly persons who have agreed to go on living at home, with some help (1 comment).

13. To meet its objectives, the Single Entry Point Project requires that all the people involved with the elderly (social workers, nurses, doctors, health professionals, informal caregivers, etc.) form a multidisciplinary team.

Degree of impact	Nursing Home		Service Provider		Hospital		Total
	N=14	%	N=16	%	N=8	%	Weighted %
Small impact	0	0	1	6	0	0	2
Medium	2	14	4	25	0	0	13
Large	3	21	2	13	3	38	24
Very large	6	43	7	44	5	63	50
Can not say	3	21	2	13	0	0	11

Comments - Teamwork is now an established fact (4 comments). Care must be taken, however, not to work far away from senior citizens, and not to increase the number of meetings and all kinds of reports (1 comment). The system needs structuring to improve communication on specific cases (1 comment).

Strong Points of the Single Entry Point Project - Several persons pointed out that the Single Entry Point Project gives the frail elderly a real opportunity to continue living at home, if they so wish (14 comments). The large number of options and available services was indicated as a strong point of the Single Entry Point Project (9 comments). Access to a more complete assessment (8 comments) and better coordination as a result of the multidisciplinary team (7 comments) were also stressed as strong points of the Single Entry Point Project. Certain positive effects of the Project were mentioned: a shorter wait before getting into a nursing home (3 comments) and better utilization of resources and available space in hospitals and nursing homes (4 comments), improved health care for the elderly (1 comment).

Points To Be Improved - Several suggestions were made concerning improved operation of the Single Entry Point Project. The following are the main ideas that emerge from the comments made:

- Assessment and the administrative process should be completed in a shorter time (5 comments).
- A standardized method of communication should be used, especially with service providers (3 comments).
- The difference between informing, motivating, and forcing should be clearly established. Seniors should be entitled to decide their future (2 comments).
- Ways should be found to improve the situation of homemakers, and as a result, the service itself: a guaranteed block of 35 to 40 hours per week, further training, additional pay for work outside regular hours or on weekends (9 comments).
- Services announced should be available days, nights, and weekends (2 comments).
- Assessment of mental health should be better (1 comment).
- The impact of the Single Entry Point Project on informal caregivers should be assessed in detail and appropriate action taken (2 comments).
- The impact of the Single Entry Point Project on institutions should be given consideration, and an effort made to provide the necessary adjustments in resources and the environment (4 comments).

APPENDIX F

COMPILATION OF ANSWERS TO THE STAKEHOLDERS QUESTIONNAIRE

A questionnaire was sent, in December 1990, to the Presidents of 18 provincial associations and groups having a real interest in the Single Entry Point project. This questionnaire asked the opinion of these associations and groups on the objectives of the Single Entry Point project, on some impacts of this model, on the strong points and on the improvements to be made.

A total of 12 responses were received. In addition, a letter from the Nursing Home Association of New Brunswick informed us that they were presently doing their own study of the impacts of the Single Entry Point project and although they appreciated having the opportunity to express their point of view through our study, it seemed to them to be not appropriate to do so at this time.

The following associations and groups responded:

Canadian Physiotherapy Association - New Brunswick Chapter
New Brunswick Association of Occupational Therapists
New Brunswick Association of Special Care Homes
New Brunswick Hospital Association
New Brunswick Nurses Association
New Brunswick Home Economics Association (4 members)
New Brunswick Mental Health Commission
New Brunswick Senior Citizen's Federation
Victorian Order of Nurses
Canadian Red Cross Society
Alzheimer's Society
New Brunswick Medical Society (8 members)

FIRST PART - The Single Entry Point Project has several objectives relating to the frail elderly clientele, people at risk of loosing their independence. We would like to know the opinion of your association on the following objectives:

1. The Single Point Entry Project seeks to maintain the independence of the frail elderly living at home by offering them the needed services through community social services and the Extra-Mural Hospital.

   (Scale: hardly agree = 1; agree = 2; largely agree = 3; greatly agree = 4)

   AVERAGE RESULT: LARGELY AGREE (3,4)

2. The Single Point Entry Project seeks to maintain the independence of the frail elderly by maintaining or increasing their capacity to care for themselves so they may continue to live as long as possible in their home environment.

   (Scale: hardly agree = 1; agree = 2; largely agree = 3; greatly agree = 4)

   AVERAGE RESULT: LARGELY AGREE (3,3)

3. When a frail elderly person has someone in his or her surroundings that cares for him or her, the Single Point Entry seeks to maintain or increase the capacity of this informal caregiver so the frail elderly person can continue to live as long as possible in his or her home environment.

   (Scale: hardly agree = 1; agree = 2; largely agree = 3; greatly agree = 4)

   AVERAGE RESULT: LARGELY AGREE (3,2)

4. The Single Point Entry Project seeks to involve the elderly person or the informal caregiver whose lives are affected by a decision in the process of arriving at that decision.

   (Scale: hardly agree = 1; agree = 2; largely agree = 3; greatly agree = 4)

   AVERAGE RESULT: GREATLY AGREE (3,7)

5. The Single Entry Point Project seeks to allow the elderly to consider Nursing Homes (institutional environment) only after all community options have been considered.

   (Scale: hardly agree = 1; agree = 2; largely agree = 3; greatly agree = 4)

   AVERAGE RESULT: LARGELY AGREE (3,1)

Several comments made in the responses to one or the other of the questions in this first part emphasized that meeting the objectives of the Single Entry Point project depended on the availability of all the services in the model as wells as on a better awareness of the needs of the informal caregivers and on a better support system for these key people in the model.

SECOND PART - The objective and procedures of the Single Entry Point Project have already made some impacts. We wish to know the changes that have occurred as a resultand the degree of change involved.

6. As a result of the Single Entry Point Project, each region would have to enhance or develop a group of community services such as homemaker services, in-home relief services, meal services and friendly visiting services, physiotherapy, ergotherapy, etc. to meet the needs of the frail elderly.

   (Scale: small impact = 1; medium = 2; large = 3; very large = 4)

   AVERAGE RESULT: LARGE IMPACT (2,9)

7. Community services will change clientele as a result of the Single Entry Point Project.

   (Scale: small impact = 1; medium = 2; large = 3; very large = 4)

   AVERAGE RESULT: MEDIUM IMPACT (2,4)

8. Institutions (hospitals, nursing homes, etc.) will change clientele as a result of the Single Entry Point Project.

   (Scale: small impact = 1; medium = 2; large = 3; very large = 4)

   AVERAGE RESULT: LARGE IMPACT (3,1)

9. As a result of the Single Entry Point Project, the members of your association involved with the frail elderly will have to reassess their personal attitudes and their professional approach based on this clientele.

   (Scale: small impact = 1; medium = 2; large = 3; very large = 4)

   AVERAGE RESULT: MEDIUM IMPACT (1,8)

10. As a result of the Single Entry Point Project, the population in general and the senior citizen in particular will have to understand the importance of accepting personal responsibility for health.

    (Scale: small impact = 1; medium = 2; large = 3; very large = 4)

    AVERAGE RESULT: LARGE IMPACT (2,8)

11. To meet its objectives, the Single Entry Point Project requires that all the people involved with the elderly (social workers, nurses, doctors, health professionals, informal caregivers, etc.) form a multidisciplinary team.

(Scale: small impact = 1; medium = 2; large = 3; very large = 4)

AVERAGE RESULT: LARGE IMPACT (2,8)

12. Other probable impacts and their degree of impact according to the members of your association: a synthesis of the comments made in the responses to these questions of the second part is found in Chapter X of the report.

THIRD PART - Following the Single Entry Point Pilot Project of this year, we would like to know the opinion of your association on what would make the Single Entry Point Project a success and what improvements should be made.

13. Please describe two of the strong points of the present Single Entry Point Pilot Project.

The strong points of the Single Entry Point project indicated by the twelve stakeholders who responded to the questionnaire can be categorized into three groups. The frail elderly: it was emphasized that giving them the possibility of staying as long as possible in their family and social environment meant maintaining their autonomy and their personal value as human beings as well. The decrease in the waiting list translates into quicker access to nursing homes for people needing such care. Several strong points of the Single Entry Point project are professionally orientated: the multidisciplinary nature providing for a holistic approach is a strong point of the model. They perceive a better coordination and a better assessment which means, for one, a better utilization of the financial and human resources in the community, in nursing homes, and in hospitals. One person in the group noted that the Single Entry Point project sparked community spirit.

14. Please describe two points to be improved in the present Single Entry Point Pilot Project.

The improvements suggested by the respondents are presented below as brief statements. The synthesis of these comments is presented in Chapter VII. The suggestions are grouped in the Chapter by theme.

- Improve the communication between the Single Entry Point team and the attending physician.
- Involve the family doctor at all stages.
- Develop a mechanism, for example, a form, to single out the case to the doctor by emphasizing the urgency and the aim of the referral.
- Reinforce multidisciplinary cooperation.
- Increase the awareness of very elderly people's problems on the part of the assessors.
- Make the procedure more economical from a time point of view.
- Increase the involvement of service agencies in the project; involve them from the beginning.
- Help (financially, for one) the associations to establish and coordinate self-help groups.
- Inform formal or informal caregivers of specific needs related to certain health problems, such as Alzeimer's Disease.
- Proceed by observation rather than by questioning to assess the functional capacities of the elderly.
- Let specialists assess functional capacities.
- Emphasize in the multidisciplinary assessment form the indicators for a need to refer for specialized assessment.
- Let occupational therapists assess mobility and capacities as relates to everyday living.
- Ensure that all the services are available including geriatric assessment and day care in every region.
- Make all existing services available in every region.
- Make the services available at any time: 24 hours a day, 7 days a week.
- Provide more support to informal caregivers as needed.
- Offer an at home mental health service.
- Ensure that the choices of the elderly and their informal caregivers are respected.

APPENDIX G

DATA FOR THE GENERAL PROFILES OF DIFFERENT CLIENTELES PARTICIPATING IN THE SINGLE ENTRY POINT PROJECT

From November 1, 1989 to September 30, 1990, information was gathered through the New Brunswick Assessment and Continuing Care Instrument to draw the general progiles of different clienteles participating in the Single Entry Point project. The general profile consists of the description of the clienteles regarding the following characteristics:

Age
Sex
Language
Marital status
Who they live with
Setting they live in
Self-perception of health
Frequency of medical visits
Need for a caregiver
Availability of a caregiver
Acceptance of help
Identified informal caregiver
Relationship with caregiver
Identified additional caregiver
Degree of risk if no caregiver
Annual income
Source of referral to SEP

Such a profile was compiled for the frail elderly on the demonstration cohort designed to study the target clientele of the enriched services of the Single Entry Point model (Chapter II of the report), for a group of cases chosen to study the existing caseload (Chapter V of the report), and for two groups of cases chosen for a study of the Nursing Home Waiting List (Chapter VIII of this report). Nursing Home Waiting List (Chapter VIII of this report).

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
AGE																
Fredericton																
Less than 65	0	0					2	3	0	0	1	4	0	0	0	0
65-69	1	2					9	15	3	9	2	7	1	4	0	0
70-74	12	20					8	13	6	18	5	19	1	4	7	23
75-79	6	10					11	18	5	15	3	11	2	8	2	7
80-84	14	23					16	27	7	21	4	15	6	23	11	37
85-89	13	22					11	18	4	12	6	22	4	15	5	17
90-94	10	17					1	2	8	24	5	19	8	31	3	10
95-102	4	7					2	3	0	0	0	0	4	15	2	7
Missing information											1	4				
Total	60	100					60	100	33	100	27	100	26	100	30	100
Pén. acad.																
Less than 65	0	0					0	0	0	0	0	0	0	0	5	17
65-69	5	9					12	24	1	4	0	0	1	7	1	3
70-74	1	2					8	16	3	12	3	12	0	0	2	7
75-79	13	23					7	14	7	28	7	28	6	43	7	23
80-84	17	30					13	27	5	20	8	32	0	0	3	10
85-89	14	25					7	14	3	12	5	20	5	36	9	30
90-94	5	9					2	4	2	8	1	4	2	14	3	10
95-102	2	4					0	0	1	4	0	0	0	0	0	0
Missing information									3	12	1	4				
Total	57	100					49	100	25	100	25	100	14	100	30	100
SEX																
Fredericton																
Male	15	25					19	32	8	24	5	19	8	31	12	40
Female	45	75					41	68	25	76	22	81	18	69	18	60
Total	60	100					60	100	33	100	27	100	26	100	30	100
Pén. acad.																
Male	21	37					16	33	11	44	9	36	7	50	19	63
Female	36	63					33	67	14	56	16	64	7	50	11	37
Total	57	100					49	100	25	100	25	100	14	100	30	100

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
LANGUAGE																
Fredericton																
English	48	80														
French	0	0														
Both	12	20														
Total	60	100														
Pén. acad.																
English	1	2														
French	49	86														
Both	7	12														
Total	57	100														
MARITAL STATUS																
Fredericton																
Bachelor	10	17					3	5	5	15	3	11	7	27	6	20
Married	20	33					23	38	5	15	6	22	7	27	11	37
Separ	0	0					1	2	0	0	1	4	0	0	0	0
Widow	30	50					32	53	21	64	17	63	12	46	11	37
Missing information							1	2	2	6					2	7
Total	60	100					60	100	33	100	27	100	26	100	30	100
Pén. acad.																
Bachelor	4	7					4	8	2	8	3	12	3	21	6	20
Married	28	49					14	29	9	36	6	24	5	36	13	43
Separ	0	0					4	8	0	0	5	20	0	0	1	3
Widow	24	42					27	55	13	52	10	40	5	36	10	33
Missing information	1	2							1	4	1	4	1	7		
Total	57	100					49	100	25	100	25	100	14	100	30	100
LIVING WITH																
Fredericton																
Alone	13	22	12	24	11	22	20	33	21	64	15	56	6	23	5	17
With spouse	19	32	16	32	16	32	20	33	3	9	3	11	5	19	7	23
With spouse and children	2	3	2	4	2	4	2	3	2	6	1	4	2	8	2	7
With daughter	4	7	3	6	3	6	7	12	0	0	2	7	3	12	1	3
With son	2	3	2	4	2	4	2	3	3	9	2	7	1	4	4	13
With other relative	3	5	3	6	2	4	3	5	1	3	0	0	1	4	0	0
Paid care	8	13	5	10	5	10	2	3	0	0	1	4	4	15	1	3
Other	8	13	7	14	9	18	4	7	3	9	3	11	4	15	10	33
Missing information	1	2														
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
Alone	7	12	5	12	4	10	12	24	8	32	8	32	1	7	2	7
With spouse	22	39	13	32	12	29	10	20	8	32	3	12	6	43	7	23
With spouse and children	3	5	3	7	4	10	3	6	0	0	2	8	0	0	3	10
With daughter	12	21	12	29	10	24	5	10	0	0	2	8	1	7	1	3
With son	8	14	5	12	5	12	7	14	2	8	2	8	2	14	2	7
With other relative	2	4	1	2	2	5	5	10	0	0	2	8	1	7	0	0
Paid care	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0
Other	2	4	2	5	4	10	6	12	7	28	6	24	2	14	15	50
Missing information	1	2											1	7		
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
LIVING IN																
Fredericton																
Own house					28	56	35	58	25	76	15	56			11	37
Rented house					1	2	1	2	0	0	0	0			0	0
Rented apartment					3	6	8	13	3	9	4	15			2	7
Senior Citizen's house					1	2	2	3	2	6	3	11			1	3
Room and board					0	0	2	3	0	0	0	0			0	0
Special care home					7	14	0	0	1	3	1	4			0	0
Other					10	20	11	18	1	3	2	7			13	43
Missing information					0	0	1	2	1	3	2	7			3	10
Total					50	100	60	100	33	100	27	100			30	100
Pén. acad.																
Own house					21	51	27	55	16	64	12	48			11	37
Rented house					1	2	2	4	0	0	1	4			0	0
Rented apartment					3	7	4	8	0	0	1	4			0	0
Senior Citizen's house					2	5	3	6	4	16	2	8			2	7
Room and board					1	2	5	10	0	0	1	4			0	0
Special care home					2	5	1	2	1	4	4	16			2	7
Other					11	27	7	14	4	16	4	16			15	50
Total					41	100	49	100	25	100	25	100			30	100
PERCEPTION OF HEALTH																
Fredericton																
Good					22	44	27	45	21	64	9	33			11	37
Fair					19	38	21	35	6	18	13	48			8	27
Poor					9	18	12	20	6	18	5	19			8	27
Missing information															3	10
Total					50	100	60	100	33	100	27	100			30	100
Pén. acad.																
Good					11	27	16	33	17	68	5	20			6	20
Fair					22	54	29	59	5	20	12	48			11	37
Poor					8	20	4	8	3	12	7	28			12	40
Missing information											1	4			1	3
Total					41	100	49	100	25	100	25	100			30	100
VISITS TO DOCTOR PER YEAR																
Fredericton																
0					1	2	0	0	0	0	0	0			0	0
(1-2)					10	20	17	28	13	39	7	26			4	13
(3-4)					12	24	12	20	7	21	5	19			2	7
(5-6)					3	6	2	3	3	9	2	7			2	7
(7-12)					9	18	16	27	8	24	9	33			2	7
(13-26)					2	4	1	2	1	3	1	4			0	0
(27-52)					2	4	1	2	0	0	0	0			3	10
(+ 52)					0	0	0	0	0	0	1	4			0	0
As needed					6	12	7	12	0	0	0	0			5	17
Hospital					2	4	1	2	0	0	1	4			3	10
Other					3	6	1	2	1	3	0	0			5	17
Missing information							2	3			1	4			4	13
Total					50	100	60	100	33	100	27	100			30	100

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
VISITS TO DOCTOR PER YEAR																
Pén. acad.																
0					2	5	3	6	0	0	0	0			1	3
(1-2)					7	17	8	16	2	8	3	12			2	7
(3-4)					5	12	4	8	3	12	2	8			2	7
(5-6)					4	10	4	8	4	16	1	4			2	7
(7-12)					3	7	4	8	3	12	6	24			1	3
(13-26)					0	0	2	4	0	0	0	0			0	0
(27-52)					0	0	1	2	1	4	1	4			1	3
(+ 52)					0	0	0	0	1	4	0	0			0	0
As needed					10	24	18	37	10	40	8	32			10	33
Hospital					0	0	0	0	1	4	1	4			5	17
Other					7	17	3	6	0	0	1	4			3	10
Missing information					3	7	2	4	0	0	2	8			3	10
Total					41	100	49	100	25	100	25	100			30	100
CAREGIVER REQUIRED																
Fredericton																
No	8	13	6	12	9	18	12	20	6	18	6	22	5	19	2	7
Yes	47	78	39	78	40	80	46	77	24	73	21	78	20	77	25	83
?	5	8	5	10	1	2	2	3	3	9			1	4	3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
No	12	21	7	17	5	12	9	18	4	16	1	4	2	14	6	20
Yes	44	77	33	80	34	83	40	82	21	84	23	92	11	79	24	80
Missing information	1	2	1	2	2	5	0	0	0	0	1	4	1	7	0	0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
INFORMAL CAREGIVER AVAILABLE																
Fredericton																
No	7	12	5	10	8	16	9	15	2	6	2	7	3	12	12	40
Yes	40	67	34	68	41	82	48	80	25	76	23	85	18	69	14	47
Missing information	13	22	11	22	1	2	3	5	6	18	2	7	5	19	4	13
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
No	3	5	2	5	4	10	10	20	7	28	8	32	1	7	16	53
Yes	50	88	37	90	35	85	37	76	18	72	16	64	10	71	13	43
Missing information	4	7	2	5	2	5	2	4			1	4	3	21	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
ACCEPTANCE OF HELP																
Fredericton																
No	1	2	0	0	3	6	3	5	0	0	0	0	1	4	1	3
Yes	44	73	36	72	42	84	49	82	25	76	25	93	20	77	16	53
NP/?	15	25	14	28	5	10	8	13	8	24	2	7	5	19	13	43
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
No	1	2	0	0	0	0	3	6	1	4	2	8	0	0	0	0
Yes	49	86	37	90	39	95	44	90	23	92	20	80	10	71	27	90
NP/?	7	12	4	10	2	5	2	4	1	4	3	12	4	29	3	10
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
INFORMAL CAREGIVER KNOWN																
Fredericton																
No	2	3	1	2	8	16	11	18	1	3	4	15	0	0	11	37
Yes	58	97	49	98	42	84	48	80	26	79	22	81	26	100	18	60
NP/?							1	2	6	18	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
INFORMAL CAREGIVER KNOWN																
Pén. acad.																
No	1	2	1	2	0	0	0	0	4	16	3	12	1	7	4	13
Yes	56	98	40	98	41	100	47	96	21	84	22	88	13	93	26	87
NP/?							2	4								
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
RELATIONSHIP WITH CAREGIVER																
Fredericton																
Daughter	8	13			9	14	17	28	3	9	6	22	5	19	5	17
Son	6	10			9	16	6	10	10	30	3	11	3	12	4	13
Spouse	12	20			14	28	13	22	4	12	4	15	3	12	5	17
Relatives	8	13			11	22	7	12	8	24	8	30	4	15	4	13
Friend	1	2			1	2	3	5	1	3	0	0	0	0	0	0
Care home	4	7			0	0	0	0	0	0	0	0	3	12	0	0
NP/?	21	35			6	12	14	23	7	21	6	22	8	31	12	40
Total	60	100			50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
Daughter	21	37			21	51	19	39	4	16	9	36	3	21	5	17
Son	10	18			7	17	8	16	4	16	5	20	2	14	7	23
Spouse	4	7			7	17	6	12	7	28	2	8	1	7	7	23
Relatives	4	7			2	5	13	27	3	12	3	12	0	0	6	20
Friend	3	5			3	7	1	2	1	4	3	12	1	7	1	3
Care home	4	7			0	0	0	0	0	0	0	0	4	29	0	0
NP/?	11	19			1	2	2	4	6	24	3	12	3	21	4	13
Total	57	100			41	100	49	100	25	100	25	100	14	100	30	100
ADDITIONAL CAREGIVER																
Fredericton																
None	37	62	30	60	40	80	40	67	20	61	14	52	11	42	26	87
One	23	38	20	40	10	20	19	32	7	21	12	44	15	58	3	10
NP/?							1	2	6	18	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
None	20	35	16	39	18	44	19	39	14	56	11	44	6	43	20	67
One	37	65	25	61	22	54	28	57	11	44	14	56	8	57	10	33
NP/?					1	2	2	4								
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
RISK IF NO INFORMAL CAREGIVER																
Fredericton																
No	10	17	10	20	7	14	25	42	16	48	9	33	10	38	1	3
Yes	39	65	32	64	42	84	33	55	17	52	17	63	14	54	25	83
Missing information	11	18	8	16	1	2	2	3	0	0	1	4	2	8	4	13
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
No	11	19	13	32	13	32	29	59	25	100	19	76	3	21	2	7
Yes	46	81	28	68	28	68	20	41	0	0	4	16	11	79	28	93
Missing information											2	8				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
ANNUAL INCOME																
Fredericton																
Less than 10 000					15	30	21	35	17	52	12	44			15	50
(10 000-14 999)					17	34	18	30	5	15	9	33			9	30
(15 000-19 999)					9	18	11	18	7	21	4	15			2	7
(20 000+)					8	16	8	13	3	9	1	4			1	3
None divulged					1	2	2	3	1	3	1	4			3	10
Total					50	100	60	100	33	100	27	100			30	100

Characteristic per region	Demonstration cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March '90		Sept '90				System		SW-Client		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
ANNUAL INCOME																
Pén. acad.																
Less than 10 000					25	61	33	67	15	60	16	64			24	80
(10 000-14 999)					12	29	13	27	6	24	7	28			2	7
(15 000-19 999)					3	7	2	4	4	16	1	4			0	0
(20 000+)					1	2	1	2	0	0	1	4			1	3
None divulged					0	0	0	0	0	0	0	0			3	10
Total					41	100	49	100	25	100	25	100			30	100
REFERRAL SOURCE TYPE																
Fredericton																
Public Health							3	5							0	0
Hospital							17	28							9	30
Health-other							3	5							2	7
Homemaker							3	5							0	0
ncome Maintenance Div.							1	2							0	0
Other Social Agencies							6	10							1	3
Relatives							15	25							9	30
Community-Other							6	10							1	3
Self Referral							3	5							0	0
Missing information							3	5							8	27
Total							60	100							30	100
Pén. acad.																
Public Health							1	2							0	0
Hospital							0	0							1	3
Doctor							3	6							2	7
Health-other							2	4							1	3
Homemaker							1	2							0	0
ncome Maintenance Div.							1	2							0	0
Other Social Agencies							26	53							22	73
Community-Other							2	4							0	0
Self Referral							13	27							4	13
Total							49	100							30	100

APPENDIX H

DATA FOR THE PROFILES OF NEEDS OF DIFFERENT CLIENTELES PARTICIPATING IN THE SINGLE ENTRY POINT PROJECT

From November 1, 1989 to September 30 1990, information was gathered through the New Brunswick Assessment and Continuing Care Instrument to draw the profiles of needs of different clienteles participating in the Single Entry Point project. The profile of needs consists of the results of the multidisciplinary assessment made to determine the seniors' needs in six categories that, while distinct, are interrelated in terms of their reciprocal effects.

1) Physical health status - Around twenty elements were used to define and assess their physical health. The information gathered dealt with communication (vision, hearing, expression, comprehension), personal organization (medications, sleep, diet), and the main bodily functions (respiration, circulation, elimination).
2) Mobility - Limited muscle strength, impaired sensation, impaired coordination, rigidity, and impaired balance are some of the physical handicaps that may affect the elderly and reduce their mobility both inside and outside the home.
3) Activities of daily living - Eating, dressing, grooming, and such activities are considered essential to individual survival and well-being. Preserving one's autonomy means preserving a sufficiently high level of physical and mental health to be able to carry out these daily living activities by oneself.
4) Instrumental activities of daily living - These take in a series of activities that must be performed on a daily basis for a household to function smoothly: for example, shopping, meal preparation, housecleaning, and banking.
5) Mental health status - Mental health is the mainstay of individual autonomy. Awareness, orientation in time and space, memory, and judgment/decision-making ability were the factors used to define mental health in this context.
6) Psychosocial status - The degree to which participation in family and social life is satisfactory and pleasant depends on whether the senior is overwhelmed or not by problems such as anxiety, depression, and tendencies toward suspiciousness or aggression. A set of seventeen elements were examined under this heading.

To report the needs, a four point scale has been used for the first five categories of needs and a three point scale has been used for the psychosocial status. These scale are defined as follows:

Four point scale:

1 No problem or alteration and/or total ability to manage by onself
2 Some problem or alteration and/or ability to manage with some assistance
3 Severe problem or alteration and/or ability to manage with regular supervision
4 Very severe problem or alteration and/or inability to manage by oneself, need for constant supervision

Three point scale:

1 No problem; ability to act without supervision; no intervention necessary
2 Existence of problem; need of regular supervision; regular intervention required
3 Existence of problem; constant supervision or frequent interventions required.

Such a profile of needs was compiled for the frail elderly on the demonstration cohort designed to study the target clientele of the enriched services of the Single Entry Point model (Chapter II of the report), for a group of cases chosen to study the existing caseload (Chapter IX) and for two groups of cases chosen for a study of the Nursing Home Waiting List (Chapter VIII).

Profil of Needs per Region	Demonstration Cohort						Other Cases Studied						Nursing Home Waiting List			
	Initial cohort		Present cohort				New Cases		Reassessed Cases							
			March'90		Sept'90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
PHYSICAL HEALTH STATUS																
Management of Medications																
Fredericton																
1) No problem	35	58	29	58	18	36	33	55	25	76	16	59	21	81	3	10
2) Some problems	3	5	3	6	3	6	6	10	2	6	2	7	0	0	3	10
3) Severe problems	5	8	5	10	6	12	2	3	1	3	0	0	1	4	1	3
4) Very severe problems	13	22	11	22	17	34	15	25	3	9	6	22	3	12	19	63
NP or ?	4	7	2	4	6	12	4	7	2	6	3	11	1	4	4	13
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	24	42	17	41	14	34	38	78	21	84	17	68	4	29	6	20
2) Some problems	3	5	3	7	0	0	2	4	0	0	1	4	2	14	1	3
3) Severe problems	3	5	2	5	4	10	0	0	0	0	1	4	0	0	1	3
4) Very severe problems	26	46	18	44	23	56	7	14	4	16	6	24	7	50	22	73
NP or ?	1	2	1	2			2	4					1	7		
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Vision																
Fredericton																
1) No problem	34	57	28	56	27	54	48	80	28	85	21	78	14	54	22	73
2) Some problems	19	32	17	34	17	34	8	13	3	9	4	15	8	31	7	23
3) Severe problems	4	7	3	6	2	4	2	3	1	3	0	0	2	8	0	0
4) Very severe problems	0	0	0	0	0	0	1	2	0	0	1	4	2	8	0	0
NP or ?	3	5	2	4	4	8	1	2	1	3	1	4		0	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	38	67	26	63	27	66	45	92	23	92	19	76	10	71	21	70
2) Some problems	16	28	12	29	8	20	3	6	2	8	4	16	3	21	7	23
3) Severe problems	3	5	3	7	6	15	1	2	0	0	1	4	1	7	2	7
4) Very severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Hearing																
Fredericton																
1) No problem	40	67	34	68	26	52	49	82	27	82	15	56	16	62	19	63
2) Some problems	14	23	13	26	17	34	9	15	5	15	7	26	5	19	8	27
3) Severe problems	3	5	2	4	3	6	1	2	0	0	3	11	3	12	1	3
4) Very severe problems	2	3	1	2	0	0	0	0	0	0	1	4	2	8	1	3
NP or ?	1	2			4	8	1	2	1	3	1	4	0	0	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	32	56	23	56	22	54	43	88	23	92	19	76	6	43	18	60
2) Some problems	21	37	15	37	16	39	4	8	0	0	2	8	7	50	9	30
3) Severe problems	3	5	2	5	2	5	2	4	1	4	2	8	1	7	2	7
4) Very severe problems	1	2	1	2	1	2	0	0	1	4	1	4	0	0	1	3
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Expression-communication																
Fredericton																
1) No problem	51	85	43	86	38	76	53	88	31	94	26	96	25	96	21	70
2) Some problems	6	10	5	10	5	10	4	7	1	3	0	0	1	4	5	17
3) Severe problems	2	3	1	2	1	2	1	2	0	0	0	0	0	0	1	3
4) Very severe problems	1	2	1	2	2	4	1	2	0	0	0	0	0	0	2	7
NP or ?					4	8	1	2	1	3	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Expression-communication	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Pén. acad.																
1) No problem	52	91	37	90	36	88	49	100	24	96	22	88	13	93	25	83
2) Some problems	3	5	3	7	4	10	0	0	1	4	1	4	1	7	1	3
3) Severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
4) Very severe problems	2	4	1	2	1	2	0	0	0	0	2	8	0	0	3	10
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Receptive Language																
Fredericton																
1) No problem	55	92	45	90	43	86	53	88	32	97	26	96	26	100	24	80
2) Some problems	4	7	4	8	1	2	6	10	0	0	0	0	0	0	4	13
3) Severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4) Very severe problems	1	2	1	2	2	4	0	0	0	0	0	0	0	0	1	3
NP or ?					4	8	1	2	1	3	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	52	91	37	90	35	85	49	100	23	92	24	96	14	100	20	67
2) Some problems	5	9	4	10	6	15	0	0	1	4	0	0	0	0	5	17
3) Severe problems	0	0	0	0	0	0	0	0	0	0	1	4	0	0	1	3
4) Very severe problems	0	0	0	0	0	0	0	0	1	4	0	0	0	0	4	13
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Dentition																
Fredericton																
1) No problem	27	45	19	38	17	34	44	73	19	58	10	37	11	42	13	43
2) Some problems	24	40	22	44	21	42	1	2	12	36	15	56	10	38	12	40
3) Severe problems	9	15	9	18	8	16	11	18	1	3	0	0	5	19	4	13
4) Very severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?					4	8	4	7	1	3	2	7			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	31	54	24	59	21	51	36	73	20	80	16	64	10	71	18	60
2) Some problems	18	32	12	29	17	41	11	22	2	8	5	20	2	14	9	30
3) Severe problems	8	14	5	12	3	7	2	4	3	12	2	8	2	14	2	7
4) Very severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?											2	8			1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Oral Hygiene																
Fredericton																
1) No problem	57	95	47	94	44	88	59	98	31	94	25	93	25	96	28	93
2) Some problems	3	5	3	6	2	4	1	2	1	3	0	0	1	4	1	3
3) Severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4) Very severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?					4	8			1	3	2	7			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	55	96	39	95	39	95	49	100	24	96	24	96	13	93	28	93
2) Some problems	1	2	1	2	1	2	0	0	1	4	1	4	0	0	2	7
3) Severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4) Very severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?	1	2	1	2	1	2							1	7		0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Diet																
Fredericton																
1) No problem	42	70	35	70	32	64	48	80	23	70	22	81	18	69	17	57
2) Some problems	14	23	11	22	8	16	8	13	3	9	3	11	6	23	6	20
3) Severe problems	3	5	4	8	6	12	4	7	1	3	1	4	1	4	6	20
4) Very severe problems	1	2	0	0	0	0	0	0	0	0	0	0	1	4	0	0
NP or ?					4	8			6	18	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Diet	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Pén. acad.																
1) No problem	45	79	35	85	36	88	41	84	25	100	20	80	13	93	23	77
2) Some problems	4	7	3	7	4	10	7	14	0	0	1	4	1	7	3	10
3) Severe problems	7	12	3	7	1	2	1	2	0	0	3	12	0	0	4	13
4) Very severe problems	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Hydration																
Fredericton																
1) No problem	51	85	43	86	39	78	55	92	29	88	24	89	26	100	22	73
2) Some problems	7	12	5	10	3	6	3	5	2	6	1	4	0	0	4	13
3) Severe problems	2	3	2	4	4	8	1	2	1	3	0	0	0	0	2	7
NP or ?					4	8	1	2	1	3	2	7			2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	47	82	36	88	39	95	47	96	25	100	21	84	14	100	25	83
2) Some problems	3	5	2	5	1	2	2	4	0	0	3	12	0	0	2	7
3) Severe problems	7	12	3	7	1	2	0	0	0	0	1	4	0	0	3	10
4) Very severe problems																
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Tissue-Skin Management																
Fredericton																
1) No problem	41	68	34	68	28	56	51	85	23	70	17	63	21	81	15	50
2) Some problems	4	7	3	6	5	10	1	2	1	3	2	7	2	8	1	3
3) Severe problems	8	13	8	16	4	8	1	2	3	9	3	11	2	8	1	3
4) Very severe problems	7	12	5	10	9	18	5	8	4	12	4	15	1	4	12	40
NP or ?					4	8	2	3	2	6	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	48	84	33	80	33	80	45	92	23	92	21	84	13	93	18	60
2) Some problems	0	0	0	0	5	12	2	4	0	0	0	0	1	7	1	3
3) Severe problems	4	7	3	7	0	0	0	0	1	4	2	8	0	0	1	3
4) Very severe problems	5	9	5	12	3	7	2	4	1	4	1	4	0	0	10	33
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Urinary Management																
Fredericton																
1) No problem	40	67	32	64	26	52	49	82	26	79	22	81	20	77	15	50
2) Some problems	4	7	3	6	4	8	1	2	0	0	0	0	1	4	2	7
3) Severe problems	8	13	7	14	8	16	4	7	5	15	3	11	5	19	3	10
4) Very severe problems	8	13	8	16	8	16	6	10	0	0	0	0	0	0	9	30
NP or ?					4	8			2	6	2	7			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	44	77	32	78	32	78	44	90	24	96	23	92	10	71	14	47
2) Some problems	2	4	2	5	2	5	1	2	0	0	0	0	0	0	2	7
3) Severe problems	2	4	1	2	4	10	1	2	0	0	0	0	2	14	3	10
4) Very severe problems	9	16	6	15	3	7	3	6	1	4	0	0	2	14	11	37
NP or ?											2	8				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Bowel Management																
Fredericton																
1) No problem	43	72	35	70	30	60	50	83	28	85	21	78	23	88	15	50
2) Some problems	4	7	3	6	3	6	3	5	2	6	0	0	1	4	0	0
3) Severe problems	6	10	5	10	4	8	3	5	2	6	4	15	0	0	4	13
4) Very severe problems	7	12	7	14	9	18	4	7	0	0	1	4	2	8	10	33
NP or ?					4	8			1	3	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Bowel Management	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Pén. acad.																
1) No problem	44	77	31	76	27	66	44	90	24	96	23	92	12	86	15	50
2) Some problems	4	7	3	7	8	20	2	4	0	0	1	4	0	0	1	3
3) Severe problems	2	4	2	5	3	7	1	2	0	0	1	4	1	7	3	10
4) Very severe problems	7	12	5	12	3	7	2	4	1	4	0	0	1	7	11	37
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Pain Management																
Fredericton																
1) No problem	49	82	40	80	32	64	53	88	25	76	22	81	24	92	16	53
2) Some problems	4	7	4	8	6	12	1	2	1	3	1	4	0	0	4	13
3) Severe problems	4	7	4	8	3	6	5	8	1	3	1	4	1	4	2	7
4) Very severe problems	2	3	1	2	5	10	0	0	0	0	2	7	0	0	7	23
NP or ?	1	2	1	2	4	8	1	2	6	18	1	4	1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	40	70	29	71	31	76	45	92	22	88	21	84	12	86	21	70
2) Some problems	11	19	7	17	8	20	1	2	2	8	2	8	2	14	2	7
3) Severe problems	1	2	1	2	2	5	3	6	0	0	1	4	0	0	3	10
4) Very severe problems	3	5	2	5	0	0	0	0	1	4	0	0	0	0	4	13
NP or ?	2	4	2	5							1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Sleep																
Fredericton																
1) No problem	50	83	40	80	33	66	55	92	30	91	22	81	22	85	15	50
2) Some problems	8	13	8	16	12	24	3	5	2	6	2	7	3	12	10	33
3) Severe problems	1	2	1	2	1	2	1	2	0	0	0	0	0	0	4	13
4) Very severe problems	1	2	1	2	0	0	0	0	0	0	0	0	1	4	0	0
NP or ?					4	8	1	2	1	3	3	11			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	43	75	30	73	29	71	46	94	24	96	21	84	13	93	21	70
2) Some problems	10	18	7	17	8	20	0	0	1	4	1	4	1	7	5	17
3) Severe problems	2	4	2	5	4	10	3	6	0	0	1	4	0	0	4	13
4) Very severe problems	2	4	2	5	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?											2	8				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Respiration																
Fredericton																
1) No problem	48	80	37	74	35	70	53	88	31	94	25	93	23	88	16	53
2) Some problems	5	8	4	8	6	12	1	2	1	3	0	0	1	4	3	10
3) Severe problems	5	8	3	6	4	8	2	3	0	0	1	4	2	8	6	20
4) Very severe problems	2	3	2	4	1	2	3	5	0	0	0	0	0	0	4	13
NP or ?			4	8	4	8	1	2	1	3	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	52	91	37	90	37	90	48	98	25	100	23	92	14	100	28	93
2) Some problems	1	2	0	0	1	2	1	2	0	0	0	0	0	0	0	0
3) Severe problems	3	5	3	7	3	7	0	0	0	0	1	4	0	0	1	3
4) Very severe problems	1	2	1	2	0	0	0	0	0	0	1	4	0	0	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Circulation																
Fredericton																
1) No problem	43	72	37	74	26	52	50	83	31	94	20	74	22	85	15	50
2) Some problems	6	10	5	10	7	14	2	3	0	0	1	4	2	8	2	7
3) Severe problems	9	15	6	12	9	18	4	7	1	3	2	7	2	8	3	10
4) Very severe problems	2	3	2	4	4	8	3	5	0	0	3	11	0	0	9	30
NP or ?					4	8	1	2	1	3	1	4			1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Circulation	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Pén. acad.																
1) No problem	43	75	32	78	28	68	45	92	20	80	21	84	10	71	22	73
2) Some problems	4	7	3	7	7	17	1	2	0	0	1	4	0	0	1	3
3) Severe problems	4	7	2	5	3	7	1	2	0	0	0	0	1	7	2	7
4) Very severe problems	6	11	4	10	3	7	2	4	1	4	2	8	3	21	4	13
NP or ?						0			4	16	1	4			1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Physical Function																
Fredericton																
1) No problem	33	55	28	56	18	36	42	70	27	82	17	63	20	77	7	23
2) Some problems	3	5	3	6	5	10	5	8	0	0	2	7	0	0	3	10
3) Severe problems	15	25	11	22	9	18	5	8	3	9	4	15	4	15	6	20
4) Very severe problems	9	15	8	16	13	26	7	12	2	6	2	7	2	8	12	40
NP or ?					5	10	1	2	1	3	2	7			2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	28	49	19	46	15	37	36	73	22	88	20	80	8	57	5	17
2) Some problems	7	12	4	10	5	12	1	2	1	4	1	4	2	14	3	10
3) Severe problems	14	25	11	27	16	39	7	14	1	4	3	12	3	21	12	40
4) Very severe problems	7	12	6	15	5	12	4	8	1	4	0	0	1	7	10	33
NP or ?	1	2	1	2			1	2			1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

SECOND DOMAIN: ACTIVITIES OF DAILY LIVING

Eating																
Fredericton																
1) No problem	44	73	37	74	34	68	53	88	28	85	22		22	85	13	43
2) Some problems	5	8	4	8	5	10	1	2	3	9	1		1	4	5	17
3) Severe problems	4	7	4	8	3	6	2	3	0	0	2		3	12	1	3
4) Very severe problems	7	12	5	10	4	8	4	7	2	6	1		0	0	9	30
NP or ?					4	8					1				2	7
Total	60	100	50	100	50	100	60	100	33	100	27	0	26	100	30	100
Pén. acad.																
1) No problem	43	75	31	76	28	68	46	94	24	96	24	96	10	71	20	67
2) Some problems	6	11	4	10	7	17	3	6	1	4	1	4	1	7	2	7
3) Severe problems	4	7	4	10	3	7	0	0	0	0	0	0	1	7	4	13
4) Very severe problems	2	4	1	2	2	5	0	0	0	0	0	0	1	7	3	10
NP or ?	2	4	1	2	1	2							1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Dressing																
Fredericton																
1) No problem	31	52	27	54	21	42	44	73	28	85	20	74	17	65	7	23
2) Some problems	9	15	8	16	7	14	1	2	1	3	0	0	4	15	1	3
3) Severe problems	8	13	6	12	7	14	6	10	3	9	3	11	2	8	7	23
4) Very severe problems	12	20	9	18	10	20	8	13	1	3	3	11	3	12	13	43
NP or ?					5	10	1	2			1	4			2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	28	49	19	46	16	39	39	80	22	88	20	80	7	50	5	17
2) Some problems	11	19	8	20	6	15	3	6	2	8	1	4	3	21	4	13
3) Severe problems	6	11	5	12	4	10	4	8	0	0	3	12	2	14	8	27
4) Very severe problems	11	19	8	20	9	22	3	6	1	4	1	4	1	7	12	40
NP or ?	1	2	1	2	6	15							1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Grooming	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Fredericton																
1) No problem	27	45	24	48	19	38	41	68	25	76	20	74	15	58	5	17
2) Some problems	7	12	6	12	2	4	3	5	1	3	1	4	4	15	3	10
3) Severe problems	9	15	7	14	12	24	6	10	5	15	3	11	3	12	6	20
4) Very severe problems	17	28	13	26	12	24	9	15	2	6	2	7	4	15	14	47
NP or ?					5	10	1	2			1	4			2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	32	56	21	51	16	39	40	82	22	88	22	88	8	57	5	17
2) Some problems	6	11	5	12	6	15	4	8	1	4	1	4	2	14	3	10
3) Severe problems	6	11	5	12	8	20	2	4	1	4	0	0	2	14	8	27
4) Very severe problems	12	21	10	24	11	27	3	6	1	4	2	8	1	7	13	43
NP or ?	1	2											1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Bathing																
Fredericton																
1) No problem	13	22	12	24	7	14	32	53	18	55	12	44	8	31	2	7
2) Some problems	8	13	6	12	2	4	2	3	2	6	1	4	6	23	0	0
3) Severe problems	15	25	12	24	16	32	7	12	4	12	5	19	7	27	4	13
4) Very severe problems	24	40	20	40	22	44	18	30	8	24	9	33	5	19	22	73
NP or ?					3	6	1	2	1	3					2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	9	16	5	12	7	17	25	51	18	72	13	52	2	14	1	3
2) Some problems	4	7	1	2	0	0	6	12	3	12	0	0	1	7	0	0
3) Severe problems	10	18	7	17	3	7	3	6	2	8	4	16	5	36	1	3
4) Very severe problems	33	58	28	68	31	76	15	31	2	8	7	28	5	36	26	87
NP or ?	1	2				0					1	4	1	7	2	7
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Toileting																
Fredericton																
1) No problem	36	60	29	58	28	56	49	82	32	97	21	78	17	65	8	27
2) Some problems	4	7	2	4	1	2	2	3	0	0	2	7	2	8	2	7
3) Severe problems	7	12	6	12	3	6	2	3	1	3	0	0	4	15	3	10
4) Very severe problems	12	20	12	24	15	30	5	8	0	0	4	15	2	8	15	50
NP or ?	1	2	1	2	3	6	2	3					1	4	2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	37	65	26	63	25	61	41	84	23	92	21	84	10	71	12	40
2) Some problems	6	11	5	12	4	10	2	4	1	4	2	8	1	7	4	13
3) Severe problems	3	5	2	5	5	12	4	8	0	0	0	0	1	7	1	3
4) Very severe problems	9	16	7	17	6	15	2	4	1	4	2	8	1	7	12	40
NP or ?	2	4	1	2	1	2							1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Transfer																
Fredericton																
1) No problem	38	63	32	64	28	56	47	78	31	94	21	78	20	77	13	43
2) Some problems	2	3	2	4	2	4	1	2	0	0	1	4	2	8	0	0
3) Severe problems	8	13	5	10	4	8	4	7	1	3	2	7	1	4	4	13
4) Very severe problems	12	20	11	22	15	30	7	12	1	3	3	11	3	12	11	37
NP or ?					1	2	1	2							2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	30	53	19	46	27	66	42	86	23	92	21	84	10	71	13	43
2) Some problems	8	14	7	17	3	7	2	4	0	0	1	4	1	7	3	10
3) Severe problems	3	5	2	5	3	7	2	4	0	0	1	4	1	7	3	10
4) Very severe problems	12	21	10	24	8	20	3	6	2	8	1	4	1	7	10	33
NP or ?	4	7	3	7							1	4	1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Footcare	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Fredericton																
1) No problem	9	15	7	14	3	6	26	43	9	27	11	41	5	19	2	7
2) Some problems	3	5	3	6	1	2	1	2	0	0	0	0	1	4	0	0
3) Severe problems	3	5	3	6	3	6	5	8	2	6	2	7	1	4	0	0
4) Very severe problems	45	75	37	74	39	78	28	47	22	67	14	52	19	73	26	87
NP or ?					4	8									2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	17	30	10	24	5	12	26	53	19	76	15	60	4	29	2	7
2) Some problems	9	16	7	17	3	7	1	2	0	0	2	8	1	7	0	0
3) Severe problems	2	4	1	2	2	5	2	4	1	4	0	0	2	14	0	0
4) Very severe problems	28	49	23	56	31	76	20	41	5	20	8	32	6	43	27	90
NP or ?	1	2											1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
THIRD DOMAIN: MOBILITY																
Indoor Mobility																
Fredericton																
1) No problem	40	67	35	70	31	62	51	85	30	91	22	81	20	77	13	43
2) Some problems	3	5	2	4	3	6	1	2	0	0	1	4	3	12	1	3
3) Severe problems	8	13	5	10	3	6	3	5	0	0	3	11	1	4	6	20
4) Very severe problems	9	15	8	16	11	22	5	8	3	9	1	4	2	8	8	27
NP or ?					2	4									2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	36	63	23	56	27	66	41	84	24	96	22	88	10	71	17	57
2) Some problems	7	12	6	15	3	7	2	4	0	0	2	8	2	14	0	0
3) Severe problems	5	9	5	12	2	5	1	2	0	0	0	0	0	0	1	3
4) Very severe problems	7	12	6	15	9	22	5	10	1	4	0	0	1	7	11	37
NP or ?	2	4	1	2							1	4	1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Outdoor Mobility																
Fredericton																
1) No problem	27	45	24	48	17	34	38	63	21	64	15	56	16	62	7	23
2) Some problems	3	5	3	6	2	4	1	2	0	0	1	4	3	12	1	3
3) Severe problems	8	13	6	12	6	12	8	13	2	6	3	11	2	8	7	23
4) Very severe problems	22	37	17	34	23	46	13	22	10	30	8	30	5	19	13	43
NP or ?					2	4									2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	23	40	12	29	11	27	39	80	23	92	17	68	7	50	9	30
2) Some problems	5	9	5	12	5	12	3	6	0	0	3	12	2	14	0	0
3) Severe problems	10	18	10	24	10	24	1	2	0	0	2	8	1	7	2	7
4) Very severe problems	18	32	14	34	15	37	5	10	2	8	3	12	3	21	18	60
NP or ?	1	2					1	2					1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Stairs-Ramps																
Fredericton																
1) No problem	23	38	19	38	16	32	29	48	19	58	9	33	14	54	8	27
2) Some problems	4	7	4	8	1	2	4	7	1	3	1	4	3	12	1	3
3) Severe problems	11	18	8	16	7	14	11	18	3	9	4	15	3	12	3	10
4) Very severe problems	21	35	18	36	24	48	15	25	10	30	13	48	5	19	16	53
NP or ?	1	2	1	2	2	4	1	2					1	4	2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	8	14	5	12	6	15	28	57	16	64	10	40	1	7	4	13
2) Some problems	3	5	2	5	0	0	3	6	4	16	3	12	1	7	0	0
3) Severe problems	5	9	5	12	9	22	4	8	1	4	1	4	2	14	2	7
4) Very severe problems	21	37	16	39	25	61	13	27	3	12	6	24	3	21	14	47
NP or ?	20	35	13	32	1	2	1	2	1	4	5	20	7	50	10	33
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial		Present cohort				New		Reassessed Cases				Waiting List			
	cohort		March '90		Sept '90		Cases		System		SW-Clien		Group A		Group B	
Transportation	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Fredericton																
1) No problem	16	27	13	26	8	16	25	42	12	36	8	30	10	38	3	10
2) Some problems	6	10	6	12	4	8	5	8	7	21	5	19	4	15	3	10
3) Severe problems	11	18	8	16	8	16	5	8	1	3	3	11	3	12	3	10
4) Very severe problems	27	45	23	46	27	54	23	38	13	39	11	41	9	35	19	63
NP or ?					3	6	2	3							2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	20	35	12	29	5	12	29	59	20	80	16	64	7	50	7	23
2) Some problems	7	12	4	10	4	10	5	10	0	0	5	20	2	14	1	3
3) Severe problems	17	30	15	37	10	24	2	4	2	8	2	8	3	21	5	17
4) Very severe problems	11	19	9	22	22	54	13	27	3	12	2	8	1	7	16	53
NP or ?	2	4	1	2									1	7	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
FOURTH DOMAIN: INSTRUMENTAL ACTIVITIES																
Shopping																
Fredericton																
1) No problem	6	10	6	12	3	6	18	30	12	36	6	22	5	19	0	0
2) Some problems	3	5	3	6	1	2	3	5	2	6	2	7	3	12	0	0
3) Severe problems	7	12	6	12	5	10	10	17	3	9	7	26	4	15	3	10
4) Very severe problems	43	72	35	70	38	76	27	45	16	48	11	41	14	54	24	80
NP or ?	1	2			3	6	2	3			1	4			3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	1	2	0	0	0	0	18	37	15	60	7	28	0	0	0	0
2) Some problems	3	5	2	5	0	0	5	10	2	8	3	12	1	7	0	0
3) Severe problems	15	26	11	27	5	12	5	10	4	16	5	20	5	36	2	7
4) Very severe problems	36	63	27	66	36	88	21	43	4	16	9	36	6	43	27	90
NP or ?	2	4	1	2							1	4	2	14	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Banking																
Fredericton																
1) No problem	12	20	11	22	6	12	27	45	14	42	10	37	10	38	3	10
2) Some problems	3	5	3	6	2	4	1	2	1	3	0	0	2	8	1	3
3) Severe problems	5	8	3	6	2	4	9	15	5	15	3	11	3	12	2	7
4) Very severe problems	39	65	33	66	37	74	22	37	13	39	14	52	11	42	21	70
NP or ?	1	2			3	6	1	2							3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	10	18	8	20	1	2	24	49	19	76	11	44	1	7	1	3
2) Some problems	5	9	4	10	2	5	5	10	0	0	2	8	1	7	0	0
3) Severe problems	13	23	10	24	2	5	3	6	1	4	2	8	4	29	2	7
4) Very severe problems	27	47	18	44	22	54	17	35	5	20	9	36	6	43	26	87
NP or ?	2	4	1	2	14	34					1	4	2	14	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Money Management																
Fredericton																
1) No problem	11	18	10	20	9	18	31	52	21	64	13	48	9	35	3	10
2) Some problems	4	7	4	8	1	2	8	13	3	9	0	0	3	12	1	3
3) Severe problems	5	8	3	6	4	8	0	0	4	12	3	11	3	12	2	7
4) Very severe problems	39	65	33	66	33	66	20	33	5	15	11	41	11	42	21	70
NP or ?	1	2			3	6	1	2							3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	12	21	9	22	1	2	24	49	21	84	13	52	1	7	2	7
2) Some problems	5	9	4	10	3	7	5	10	0	0	1	4	1	7	0	0
3) Severe problems	13	23	10	24	12	29	4	8	0	0	2	8	4	29	2	7
4) Very severe problems	25	44	17	41	25	61	16	33	4	16	8	32	6	43	25	83
NP or ?	2	4	1	2							1	4	2	14	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
Use of Telephone	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Fredericton																
1) No problem					17	34	41	68	29	88	21	78			1	3
2) Some problems					2	4	1	2	0	0	0	0			1	3
3) Severe problems					4	8	2	3	2	6	1	4			1	3
4) Very severe problems					12	24	7	12	1	3	5	19			9	30
NP or ?					15	30	9	15	1	3					18	60
Total					50	100	60	100	33	100	27	100			30	100
Pén. acad.																
1) No problem	16	28	13	32	12	29	37	76	19	76	15	60	1	7	8	27
2) Some problems	0	0	0	0	4	10	1	2	1	4	2	8	3	21	2	7
3) Severe problems	8	14	4	10	1	2	1	2	1	4	2	8	6	43	2	7
4) Very severe problems	12	21	6	15	6	15	6	12	2	8	5	20	4	29	14	47
NP or ?	21	37	18	44	18	44	4	8	2	8	1	4			4	13
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Meal Preparation																
Fredericton																
1) No problem	7	12	5	10	3	6	25	42	16	48	8	30	5	19	1	3
2) Some problems	4	7	4	8	4	8	3	5	4	12	1	4	3	12	0	0
3) Severe problems	11	18	11	22	6	12	6	10	6	18	6	22	6	23	2	7
4) Very severe problems	37	62	30	60	34	68	23	38	7	21	12	44	12	46	24	80
NP or ?	1	2			3	6	3	5							3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	2	4	1	2	2	5	8	16	9	36	4	16	0	0	0	0
2) Some problems	3	5	3	7	1	2	9	18	4	16	1	4	2	14	0	0
3) Severe problems	13	23	12	29	4	10	7	14	2	8	3	12	1	7	1	3
4) Very severe problems	37	65	25	61	34	83	25	51	10	40	15	60	9	64	28	93
NP or ?	2	4									2	8	2	14	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
House Cleaning																
Fredericton																
1) No problem	4	7	4	8	1	2	9	15	4	12	1	4	3	12	1	3
2) Some problems	4	7	4	8	1	2	0	0	1	3	0	0	4	15	0	0
3) Severe problems	6	10	5	10	6	12	16	27	8	24	8	30	3	12	1	3
4) Very severe problems	45	75	37	74	39	78	33	55	20	61	18	67	16	62	25	83
NP or ?	1	2			3	6	2	3							3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	0	0	0	0	0	0	3	6	1	4	2	8	0	0	0	0
2) Some problems	0	0	0	0	0	0	3	6	2	8	0	0	0	0	0	0
3) Severe problems	15	26	13	32	2	5	6	12	7	28	3	12	3	21	0	0
4) Very severe problems	40	70	28	68	39	95	37	76	15	60	18	72	9	64	29	97
NP or ?	2	4									2	8	2	14	1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Repairs-Yard																
Fredericton																
1) No problem	5	8	5	10	2	4	7	12	5	15	4	15	3	12	0	0
2) Some problems	3	5	3	6	1	2	0	0	0	0	0	0	3	12	0	0
3) Severe problems	3	5	3	6	2	4	7	12	5	15	3	11	2	8	1	3
4) Very severe problems	47	78	38	76	42	84	44	73	23	70	20	74	17	65	25	83
NP or ?	2	3	1	2	3	6	2	3					1	4	4	13
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	0	0	0	0	0	0	5	10	3	12	2	8	0	0	0	0
2) Some problems	1	2	1	2	1	2	6	12	3	12	1	4	0	0	0	0
3) Severe problems	8	14	7	17	0	0	3	6	3	12	3	12	1	7	0	0
4) Very severe problems	43	75	30	73	39	95	35	71	16	64	18	72	10	71	27	90
NP or ?	5	9	3	7	1	2					1	4	3	21	3	10
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
FIFTH DOMAIN: MENTAL HEALTH																
Awareness																
Fredericton																
1) No problem	42	70	35	70	32	64	44	73	30	91	21	78	18	69	9	30
2) Some problems	11	18	9	18	9	18	7	12	2	6	5	19	6	23	7	23
3) Severe problems	5	8	4	8	7	14	7	12	1	3	1	4	1	4	11	37
4) Very severe problems	1	2	1	2	1	2	1	2	0	0	0	0	0	0	1	3
NP or ?	1	2	1	2	1	2	1	2					1	4	2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	32	56	25	61	23	56	44	90	20	80	17	68	7	50	8	27
2) Some problems	14	25	9	22	10	24	4	8	3	12	4	16	4	29	7	23
3) Severe problems	9	16	6	15	6	15	1	2	2	8	4	16	3	21	12	40
4) Very severe problems	2	4	1	2	2	5	0	0	0	0	0	0	0	0	3	10
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Orientation																
Fredericton																
1) No problem	43	72	35	70	32	64	46	77	31	94	23	85	20	77	9	30
2) Some problems	12	20	11	22	7	14	1	2	1	3	2	7	4	15	6	20
3) Severe problems	2	3	1	2	6	12	8	13	0	0	1	4	0	0	5	17
4) Very severe problems	2	3	2	4	4	8	4	7	1	3	1	4	1	4	7	23
NP or ?	1	2	1	2	1	2	1	2					1	4	3	10
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	37	65	28	68	28	68	45	92	24	96	19	76	7	50	9	30
2) Some problems	11	19	8	20	9	22	2	4	1	4	2	8	4	29	6	20
3) Severe problems	5	9	2	5	0	0	2	4	0	0	3	12	2	14	5	17
4) Very severe problems	4	7	3	7	4	10	0	0	0	0	1	4	1	7	10	33
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Memory																
Fredericton																
1) No problem	38	63	31	62	27	54	41	68	27	82	19	70	17	65	3	10
2) Some problems	13	22	12	24	9	18	8	13	4	12	5	19	7	27	10	33
3) Severe problems	4	7	3	6	7	14	4	7	2	6	2	7	0	0	7	23
4) Very severe problems	4	7	3	6	5	10	6	10	0	0	1	4	1	4	8	27
NP or ?	1	2	1	2	2	4	1	2					1	4	2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	36	63	28	68	23	56	43	88	21	84	18	72	8	57	6	20
2) Some problems	10	18	7	17	10	24	4	8	2	8	4	16	4	29	9	30
3) Severe problems	2	4	1	2	3	7	1	2	0	0	1	4	0	0	6	20
4) Very severe problems	9	16	5	12	5	12	1	2	2	8	1	4	2	14	9	30
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Judgment																
Fredericton																
1) No problem	40	67	33	66	28	56	44	73	27	82	23	85	17	65	6	20
2) Some problems	10	17	9	18	10	20	7	12	3	9	1	4	6	23	9	30
3) Severe problems	8	13	6	12	8	16	7	12	2	6	3	11	1	4	11	37
4) Very severe problems	2	3	2	4	4	8	0	0	0	0	0	0	2	8	0	0
NP or ?							2	3	1	3					4	13
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	36	63	28	68	23	56	41	84	21	84	17	68	6	43	6	20
2) Some problems	9	16	5	12	9	22	6	12	2	8	4	16	5	36	8	27
3) Severe problems	10	18	7	17	9	22	2	4	2	8	3	12	3	21	16	53
4) Very severe problems	2	4	1	2	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
SIXTH DOMAIN: PSYCHOSOCIAL STATUS																
Anxiety																
Fredericton																
1) No problem	48	80	41	82	38	76	53	88	33	100	24	89	22	85	23	77
2) Some problems	8	13	6	12	6	12	3	5	0	0	3	11	3	12	3	10
3) Severe problems	3	5	2	4	4	8	1	2	0	0	0	0	0	0	3	10
NP or ?	1	2	1	2	2	4	3	5					1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	43	75	33	80	31	76	37	76	22	88	23	92	11	79	22	73
2) Some problems	13	23	7	17	8	20	10	20	3	12	1	4	3	21	5	17
3) Severe problems	1	2	1	2	2	5	2	4	0	0	1	4	0	0	3	10
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Depression																
Fredericton																
1) No problem	50	83	43	86	39	78	56	93	31	94	23	85	24	92	18	60
2) Some problems	8	13	5	10	8	16	2	3	2	6	4	15	1	4	7	23
3) Severe problems	1	2	1	2	1	2	2	3	0	0	0	0	0	0	4	13
NP or ?	1	2	1	2	2	4							1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	46	81	34	83	37	90	43	88	24	96	23	92	11	79	25	83
2) Some problems	7	12	3	7	3	7	6	12	1	4	1	4	2	14	2	7
3) Severe problems	4	7	4	10	1	2	0	0	0	0	0	0	1	7	3	10
NP or ?											1	4				
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Suicide Ideation																
Fredericton																
1) No problem	58	97	48	96	47	94	59	98	33	100	27	100	25	96	28	93
2) Some problems	1	2	1	2	1	2	1	2	0	0	0	0	1	4	1	3
3) Severe problems	1	2	1	2	1	2	0	0	0	0	0	0	0	0	0	0
NP or ?					1	2									1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	55	96	40	98	40	98	48	98	25	100	25	100	13	93	28	93
2) Some problems	2	4	1	2	0	0	0	0	0	0	0	0	1	7	1	3
3) Severe problems	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0
NP or ?					1	2									1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Suspicious-Paranoïa																
Fredericton																
1) No problem	57	95	47	94	45	90	57	95	31	94	24	89	25	96	25	83
2) Some problems	1	2	1	2	3	6	1	2	2	6	3	11	0	0	2	7
3) Severe problems	1	2	1	2	1	2	1	2	0	0	0	0	0	0	2	7
NP or ?	1	2	1	2	1	2	1	2					1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	52	91	39	95	40	98	49	100	25	100	24	96	13	93	27	90
2) Some problems	5	9	2	5	0	0	0	0	0	0	1	4	1	7	3	10
3) Severe problems	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Agitation																
Fredericton																
1) No problem	50	83	41	82	37	74	55	92	31	94	25	93	22	85	16	53
2) Some problems	1	2	1	2	5	10	2	3	1	3	2	7	0	0	6	20
3) Severe problems	8	13	7	14	7	14	2	3	1	3	0	0	3	12	6	20
NP or ?	1	2	1	2	1	2	1	2					1	4	2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Agitation																
Pén. acad.																
1) No problem	47	82	33	80	33	80	45	92	25	100	23	92	12	86	20	67
2) Some problems	6	11	5	12	6	15	4	8	0	0	0	0	2	14	2	7
3) Severe problems	4	7	3	7	2	5	0	0	0	0	2	8	0	0	8	27
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Agression																
Fredericton																
1) No problem	52	87	42	84	39	78	57	95	32	97	25	93	22	85	21	70
2) Some problems	5	8	5	10	5	10	1	2	1	3	1	4	2	8	6	20
3) Severe problems	2	3	2	4	5	10	1	2	0	0	1	4	1	4	2	7
NP or ?	1	2	1	2	1	2	1	2					1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	48	84	34	83	36	88	48	98	24	96	22	88	12	86	18	60
2) Some problems	6	11	5	12	2	5	0	0	1	4	2	8	2	14	3	10
3) Severe problems	2	4	1	2	3	7	1	2	0	0	1	4	0	·0	9	30
NP or ?	1	2	1	2												
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Hoarding-Rummaging																
Fredericton																
1) No problem	55	92	46	92	43	86	56	93	33	100	25	93	24	92	23	77
2) Some problems	2	3	2	4	4	8	2	3	0	0	1	4	1	4	1	3
3) Severe problems	3	5	2	4	2	4	1	2	0	0	1	4	1	4	5	17
NP or ?					1	2	1	2							1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	50	88	36	88	35	85	49	100	25	100	23	92	12	86	26	87
2) Some problems	4	7	3	7	4	10	0	0	0	0	1	4	1	7	2	7
3) Severe problems	2	4	1	2	2	5	0	0	0	0	1	4	0	0	2	7
NP or ?	1	2	1	2									1	7		
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Wandering																
Fredericton																
1) No problem	55	92	48	96	44	88	56	93	32	97	26	96	25	96	24	80
2) Some problems	0	0	0	0	2	4	0	0	0	0	0	0	0	0	0	0
3) Severe problems	4	7	2	4	3	6	3	5	1	3	1	4	1	4	4	13
NP or ?	1	2			1	2	1	2							2	7
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	53	93	40	98	39	95	49	100	25	100	24	96	13	93	23	77
2) Some problems	1	2	0	0	0	0	0	0	0	0	0	0	0	0	3	10
3) Severe problems	2	4	1	2	2	5	0	0	0	0	1	4	1	7	4	13
NP or ?	1	2														
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Indisc. Ingestion																
Fredericton																
1) No problem	60	100	50	100	48	96	59	98	33	100	27	100	26	100	29	97
2) Some problems	0	0	0	0	1	2	1	2	0	0	0	0	0	0	0	0
3) Severe problems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NP or ?					1	2									0	0
															1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	55	96	40	98	40	98	49	100	25	100	24	96	14	100	27	90
2) Some problems	1	2	0	0	0	0	0	0	0	0	0	0	0	0	3	10
3) Severe problems	1	2	1	2	1	2	0	0	0	0	1	4	0	0	0	0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Substance Abuse																
Fredericton																
1) No problem	59	98	49	98	46	92	60	100	32	97	26	96	26	100	28	93
2) Some problems	1	2	1	2	0	0	0	0	1	3	1	4	0	0	0	0
3) Severe problems	0	0	0	0	2	4	0	0	0	0	0	0	0	0	1	3
NP or ?					2	4									1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem					39	95	49	100	24	96	24	96			29	97
2) Some problems					2	5	0	0	1	4	1	4			0	0
3) Severe problems					0	0	0	0	0	0	0	0			1	3
Total					41	100	49	100	25	100	25	100			30	100
Smoking																
Fredericton																
1) No problem	57	95	48	96	49	98	58	97	32	97	26	96	25	96	28	93
2) Some problems	1	2	1	2	0	0	1	2	0	0	0	0	0	0	1	3
3) Severe problems	0	0	0	0	0	0	1	2	1	3	0	0	0	0	0	0
NP or ?	2	3	1	2	1	2					1	4	1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	54	95	38	93	40	98	46	94	24	96	24	96	13	93	29	97
2) Some problems	2	4	2	5	1	2	3	6	1	4	1	4	0	0	1	3
3) Severe problems	1	2	1	2	0	0	0	0	0	0	0	0	1	7	0	0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Sexuality																
Fredericton																
1) No problem	56	93	46	92	50	100	60	100	32	97	26	96	25	96	29	97
2) Some problems	2	3	2	4	0	0	0	0	0	0	0	0	0	0	1	3
3) Severe problems	1	2	1	2	0	0	0	0	1	3	0	0	0	0	0	0
NP or ?	1	2	1	2							1	4	1	4		
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	54	95	39	95	40	98	48	98	25	100	25	100	13	93	26	87
2) Some problems	0	0	0	0	1	2	0	0	0	0	0	0	0	0	2	7
3) Severe problems	3	5	2	5	0	0	0	0	0	0	0	0	1	7	1	3
NP or ?							1	2							1	3
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Social Interaction																
Fredericton																
1) No problem	40	67	34	68	31	62	42	70	24	73	17	63	19	73	14	47
2) Some problems	18	30	14	28	15	30	2	3	2	6	1	4	5	19	7	23
3) Severe problems	2	3	2	4	4	8	16	27	7	21	8	30	2	8	9	30
NP or ?											1	4				
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	28	49	20	49	18	44	26	53	17	68	8	32	8	57	6	20
2) Some problems	11	19	8	20	13	32	10	20	5	20	9	36	3	21	3	10
3) Severe problems	18	32	13	32	10	24	11	22	2	8	8	32	3	21	21	70
NP or ?							2	4	1	4						
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Values-Beliefs																
Fredericton																
1) No problem					49	98	57	95	33	100	25	93			29	97
2) Some problems					1	2	0	0	0	0	1	4			0	0
3) Severe problems					0	0	0	0	0	0	0	0			0	0
NP or ?							3	5			1	4			1	3
Total					50	100	60	100	33	100	27	100			30	100

Profil of Needs per Region	Initial cohort		Present cohort				New Cases		Reassessed Cases				Waiting List			
			March '90		Sept '90				System		SW-Clien		Group A		Group B	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Values-Beliefs																
Pén. acad.																
1) No problem					39	95	42	86	24	96	24	96			16	53
2) Some problems					0	0	0	0	0	0	0	0			0	0
3) Severe problems					0	0	0	0	0	0	0	0			1	3
NP or ?					2	5	7	14	1	4	1	4			13	43
Total					41	100	49	100	25	100	25	100			30	100
Coping																
Fredericton																
1) No problem					44	88	26	43	33	100	23	85			19	63
2) Some problems					5	10	1	2	0	0	2	7			8	27
3) Severe problems					0	0	2	3	0	0	1	4			3	10
NP or ?					1	2	31	52			1	4				
Total					50	100	60	100	33	100	27	100			30	100
Pén. acad.																
1) No problem					36	88	41	84	25	100	23	92			25	83
2) Some problems					1	2	1	2	0	0	1	4			3	10
3) Severe problems					1	2	6	12	0	0	1	4			2	7
NP or ?					3	7	1	2								
Total					41	100	49	100	25	100	25	100			30	100
Vulnerability																
Fredericton																
1) No problem	56	93	47	94	48	96	57	95	33	100	25	93	25	96	26	87
2) Some problems	2	3	2	4	1	2	1	2	0	0	0	0	0	0	1	3
3) Severe problems	0	0	0	0	0	0	0	0	0	0	1	4	0	0	2	7
NP or ?	2	3	1	2	1	2	2	3			1	4	1	4	1	3
Total	60	100	50	100	50	100	60	100	33	100	27	100	26	100	30	100
Pén. acad.																
1) No problem	48	84	36	88	37	90	47	96	25	100	24	96	9	64	27	90
2) Some problems	7	12	3	7	2	5	2	4	0	0	1	4	4	29	2	7
3) Severe problems	0	0	0	0	1	2	0	0	0	0	0	0	0	0	1	3
NP or ?	2	4	2	5	1	2							1	7		0
Total	57	100	41	100	41	100	49	100	25	100	25	100	14	100	30	100
Potential Danger																
Fredericton																
1) No problem					42	84	54	90	30	91	17	63			20	67
2) Some problems					5	10	0	0	2	6	1	4			7	23
3) Severe problems					0	0	4	7	1	3	7	26			3	10
NP or ?					3	6	2	3			2	7				
Total					50	100	60	100	33	100	27	100			30	100
Pén. acad.																
1) No problem					38	93	48	98	23	92	21	84			21	70
2) Some problems					1	2	1	2	0	0	0	0			1	3
3) Severe problems					1	2	0	0	2	8	4	16			6	20
NP or ?					1	2									2	7
Total					41	100	49	100	25	100	25	100			30	100